



A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1915



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

28

S

32806

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. \_\_\_\_\_  
County of Bannock Primary Registration District No. 2101  
City or Town of Pacified (Name of Hospital) St. Anthony HospitalThe No. 37  
Registered No. 3484

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Benigno Marichle  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female Mexican (Write the word.)

## 6. DATE OF BIRTH

Jan 3<sup>rd</sup> 1921  
(Month) (Day) (Year)

## 7. AGE

Still Born  
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country) unknown

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country) unknown

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) St. Anthony Hospital  
(Address) Pacified, Id.

## 15.

Filed 14 1920Alfred J. Mountain  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

January 3 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

1/3 1921 to 1/3 1921  
that I last saw him live on 1/3 1921  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

## The CAUSE OF DEATH\* was as follows:

Still Born  
(Duration) Yrs. mos. ds.Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) James J. Cannon M. D.1-3 1921 (Address) Church & White Bldg.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View Jan 4 1921  
20. UNDERTAKER ADDRESS  
Chunson Hall city

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

**CERT #32910**

**YEAR 1921**

**IDAHO STILLBIRTH CERTIFICATE**

**☒ VOIDED DUP OF 1921-91023**

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Ada  
City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. ....

Primary Registration District No. ....

(No. South 12th St. St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 32944  
Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

Baby Kerley

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Feb 4 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

## 9. BIRTHPLACE

(State or Country)

Boise Idaho.

## 10. NAME OF FATHER

Raymond Kerley.

## 11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

## 12. MAIDEN NAME OF MOTHER

Wagne Manning

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm. M. Bratney  
Boise Idaho.

## 15. FILED

Feb 4 1921

R. A. White  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb 4, 1921  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Feb 4 1921 to Feb 24 1921

that I last saw him alive on Feb 24 1921  
and that death occurred on the date stated above, at Boise M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. E. Blunt M. D.

9/4 1921 (Address) Boise, Idaho.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Morris Hill Cemetery2/4 1921

## 20. UNDERTAKER

## ADDRESS

Wm. M. Bratney Boise Idaho.

1095

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Ada  
City of BoiseRegistration District No. 8Primary Registration District No. 1004  
(No. St. Luke's Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby TaylorFile No. 32959Registered No. 53

S

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Feb 20 - 1921  
(Month) (Day) (Year)

## 7. AGE

Still Born  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

None

## 9. BIRTHPLACE

(State or Country)

Boise Idaho

## 10. NAME OF FATHER

Donald Taylor

## 11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

## 12. MAIDEN NAME OF MOTHER

Grace Week

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Moscow, Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise Idaho

## 15.

Filed

2/20/21 19T. H. Pratt  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb 20, 1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 20 - 1920, to Feb 20 - 1920that I last saw him alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory Premature separation of Placenta  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. Allen Caraway M. D.2/20/21 (Address) Boise, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

## DATE OF BURIAL

2/20 1921

## 20. UNDERTAKER

W. McBratney

## ADDRESS

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
MAR 10 1921  
File No. 32960  
Registered No. 34  
S  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of Ada  
City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. \_\_\_\_\_  
Primary Registration District No. 1004  
(No. 311, Washington St.)

## 2. FULL NAME

Baby Sumaeta

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

Feb 20 1921  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?  
\_\_\_\_ Yrs. \_\_\_\_ Mos. \_\_\_\_ ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work. none  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) Boise Idaho

## 10. NAME OF FATHER

Manuel Sumaeta

## 11. BIRTHPLACE OF FATHER

(State or Country) Spain

## 12. MAIDEN NAME OF MOTHER

Christina Erasabal

## 13. BIRTHPLACE OF MOTHER

(State or Country) Spain

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Manuel Sumaeta

(Address) Boise

## 15. Filed

Feb 21 1921

R. H. Pratt  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

2 20 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

2 20 1921, to 2 20 1921

that I last saw him alive on 19

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Geo. Ollivier M. D.

7/21 1921 (Address) Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Johns Cemetery 7/21 1921

## 20. UNDERTAKER

ADDRESS

Schmidt & Wideman Boise



A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
32961  
File No.  
Registered No. 55

1. PLACE OF DEATH  
County of Ada  
City of Boise

Registration District No. 2  
Primary Registration District No. 1004  
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Walling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

6. DATE OF BIRTH Feb 16 1921  
(Month) (Day) (Year)

7. AGE If LESS than 1 day how many hrs. or min.?  
Yrs. Mos. ds.

8. OCCUPATION  
(a) Trade, profession or particular kind of work. None  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho  
(State or Country)

10. NAME OF FATHER Sidney Walling

11. BIRTHPLACE OF FATHER Idaho  
(State or Country)

12. MAIDEN NAME OF MOTHER Nettie Ingram

13. BIRTHPLACE OF MOTHER Mo.  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Sidney Walling  
(Address)

15. Filed Feb 21 1921 R. H. Pratt  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 16 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1921 to Feb 16 1921  
that I last saw him alive on Feb 16 1921  
and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH\* was as follows:  
Still born  
Placenta Previa

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. E. Shurtz M. D.

Feb 19 1921 (Address) Boise Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Masonic Cem DATE OF BURIAL Feb 18 1921

20. UNDERTAKER Sumner & Co. ADDRESS Boise Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
MAR 10 1921  
File No. 33095  
Registered No. S  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH.

County of Freemont  
City of Ashton

Registration District No. 102  
Primary Registration District No. 6  
(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Steve Barn

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX \_\_\_\_\_ 4. COLOR OR RACE \_\_\_\_\_ 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.

(Write the word.)

## 6. DATE OF BIRTH.

Feb. 2 1921  
(Month) (Day) (Year)

## 7. AGE

If LESS than 1 day  
how many \_\_\_\_\_ hrs. or  
\_\_\_\_\_ min. > |  
Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country) Ashton Idaho

## 10. NAME OF FATHER

John Koet

## 11. BIRTHPLACE OF FATHER

(State or Country) Oregon

## 12. MAIDEN NAME OF MOTHER

Alta Lee

## 13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laurie Lee

(Address) Ashton Idaho

## 15.

Filed 2/3 1921 Elmer  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

2 2 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
191..... to 191.....

that I last saw him alive on 191.....

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) E. P. Gandy M. D.

2/2 (Address) Ashton Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

Ashton Idaho

## DATE OF BURIAL

2/3 1921

## 20. UNDERTAKER

ADDRESS

RECEIVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Madison

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100Primary Registration District No. 2178

(No. .... St.)

## 2. FULL NAME

Baby Anderson RobinsonState of Idaho  
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 35152Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

m.

## 4. COLOR OR RACE

w.

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

## 6. DATE OF BIRTH.

Jan 26 1921  
(Month) (Day) (Year)

## 7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
how many .... hrs. or  
..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

still born

## 9. BIRTHPLACE

(State or Country)

Reuburg

## 10. NAME OF FATHER

Ray Robinson

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Anna Fikstad

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Oscar Fikstad

(Address)

R. H. F. Reuburg

## 15.

Filed 1/26 1921G. L. Espe

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

1 25 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

1-25-1921 to 1-25-1921

that I last saw him alive or Stretton 191

and that death occurred on the date stated above, at .... M.

The CAUSE OF DEATH\* was as follows:

Premature birth  
child not viable

(Duration) .... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) .... Yrs. .... mos. .... ds.

(Signed)

Louis F. Rich M. D.

1-26-1921 (Address) Reuburg Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death .... yrs. .... mos. .... days, State .... yrs. .... mos. .... days

Where was disease contracted

if not at place of death? .....

Former or  
usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

Sunnydale

## 20. UNDERTAKER

Ed Harris

## DATE OF BURIAL

1/27/1921

## ADDRESS

Reb.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia, PUERPERAL peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

**S** State of Idaho  
BOARD OF HEALTH.  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Ada Registration District No. 2  
City of Boise Primary Registration District No. 1008  
No. 410 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

## BUREAU OF VITAL STATISTICS

## 2. FULL NAME

Juan Amallategui

File No. 33260  
Registered No. 33260

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

Mar 9<sup>th</sup> 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or mins.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Boise, Idaho

## 10. NAME OF FATHER

J. A. Amallategui

## 11. BIRTHPLACE OF FATHER

(State or Country) Spain

## 12. MAIDEN NAME OF MOTHER

Candida Vrangas

## 13. BIRTHPLACE OF MOTHER

(State or Country) Spain

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Schreiber

(Address) Boise, Idaho

15. Filed Mar. 9 1921

R. H. Pratt  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

March 9 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19  
that I last saw him alive on 19  
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still born at 7 months

(Duration) Yrs. mos. ds.  
Contributory (Secondary) mother ill with fever  
probably influenza

(Duration) Yrs. mos. ds.  
(Signed) L. O. McCulloch M. D.

2/9 1921 (Address) Boise, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

St. John's Cemetery

## DATE OF BURIAL

3/10/1921

## 20. UNDERTAKER

Schreiber & Hidenfaden

## ADDRESS

Boise

McCulloch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



18712

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

**S** State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 2  
County of Ada RECEIVED  
Primary Registration District No. 1004  
City of Boise APR 7 1921 410 State Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL  
STATISTICS

## 2. FULL NAME

Baby Smith

File No. 33262  
Registered No. 67

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED Single  
(Write the word.)

6. DATE OF BIRTH Mar 1st 1921  
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. — ds. IF LESS than 1 day  
how many — hrs.  
or — min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work none  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Boise, Idaho  
(State or Country)

10. NAME OF FATHER L. D. Smith

11. BIRTHPLACE OF FATHER Idaho  
(State or Country)

12. MAIDEN NAME OF MOTHER Mary A. Barringer

13. BIRTHPLACE OF MOTHER Kan.  
(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. Smith

(Address) —

15. Filed Mar 2 - 1921

P. H. Cratt  
Local Registrar

16. DATE OF DEATH Mar 1st 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19 — to — 19 —  
that I last saw h — alive on — 19 —  
and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) — Yrs. — mos. — ds.

Contributory  
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) E. C. Collier M. D.

7/1 1921 (Address) Boise Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL Dry Creek Cemetery DATE OF BURIAL 3/4 1921

20. UNDERTAKER Schubert & Vidensfaden ADDRESS Boise

1612

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

## CERTIFICATE OF DEATH

S

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

APR 14 1921

37

Registration District No. 37

County of Twin Falls

City of " " County Hospital St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Taylor

File No. 33984

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

Male. White (Write the word.)

6. DATE OF BIRTH

Mar. 27 1921  
(Month) (Day) (Year)

7. AGE

Still birth.

IF LESS than 1 day  
how many X hrs.  
or X min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

County Hospital.

10. NAME OF FATHER

J. A. Taylor.

11. BIRTHPLACE OF FATHER

(State or Country)

Okla.

12. MAIDEN NAME OF MOTHER

Grace Morris.

13. BIRTHPLACE OF MOTHER

(State or Country)

Okla.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. A. Taylor  
Twin Falls, Idaho

15.

Filed Mar 28 1921

Local Registrar

16. DATE OF DEATH

March 27 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 27 1921, to Mar 27 1921

that I last saw him on Mar 27 1921

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH\* was as follows:

Contracted fulvis.

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

G. A. Dwyer M. D.

Mar 28 1921. (Address) Twin Falls

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

3/28 1921

20. UNDERTAKER

ADDRESS

J. F. Grossman

Twin Falls

11712

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **34016**  
Registered No. **123**

## 1. PLACE OF DEATH

County of .....

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. ....

Primary Registration District No. ....

St. ....

## 2. FULL NAME

**B. Rupert Howland**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

**M.**

## 4. COLOR OR RACE

**White**

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

**4 30 21**  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

**E. W. Howland**

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

**Mary Cupp**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15. Filed

**May 3 1921**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**4/30**  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

..... 19..... to ..... 19.....  
that I last saw him alive on ..... 19.....  
and that death occurred on the date stated above, at ..... M.  
The CAUSE OF DEATH\* was as follows:

**Muscarin**  
**at 5 1/2 m**  
(Duration) Yrs. mos. ds.  
Contributory (Secondary) **smallpox**  
**within 3 weeks ago**  
(Duration) Yrs. mos. ds.  
(Signed) **Ralph T. Dyer**  
**4/30 1921** (Address) **Dover**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

**Oularin Ore**

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Woods Hill Cemetery** **4/2 1921**

## 20. UNDERTAKER

## ADDRESS

**Schmidt & Holmstrom** **Boise**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **34028**  
Registered No. **138**

## 1. PLACE OF DEATH

Registration District No. **1**  
County of **Ada** Primary Registration District No. **1021**  
City of **Boise** **Washington** St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Alice Elizabeth Parkinson**  
If death occurred in a hospital, institution or camp, give its NAME instead of address.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
(Write the word.)

## 6. DATE OF BIRTH

**May 12<sup>th</sup> 1921**  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many hrs. or min.?  
Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

**none**

## 9. BIRTHPLACE

(State or Country)

**Boise, Idaho.**

## 10. NAME OF FATHER

**W.D. Parkinson**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Mo.**

## 12. MAIDEN NAME OF MOTHER

**Rose Jacobo.**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Kas.**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**W.D. Parkinson**

(Address)

**1410 N 12 Boise Id**

## 15.

Filed **May 13 1921**

**R.H. Post**  
Local Registrar

SYN-YORK CO., PRINTERS & BINDERS, BOISE 51068

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**May 12** 19**21**  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

**W** 19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

**Treadmill stroke**

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

**R.E. Shurtz**  
**Boise, Id**

M. D.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Morris Hill Cemetery**

**5/13 1921**

## 20. UNDERTAKER

## ADDRESS

**Schmidt & Vidensfaden**

**Boise**

**Dr. Shurtz**



A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 20 ds., Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Still born

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

34067  
27  
State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. S 40  
Registered No. 3585

1. PLACE OF DEATH  
County of Bannock  
City of Pocatello  
If death occurs away from usual residence, give facts called for under special information.  
2. FULL NAME Infant (Cordon)

PERSONAL AND STATISTICAL PARTICULARS  
3. SEX Female  
4. COLOR OR RACE White (Write the word.)  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
6. DATE OF BIRTH May 20 - 1921  
7. AGE Still Born  
8. OCCUPATION  
9. BIRTHPLACE Idaho  
10. NAME OF FATHER Edwin B. Cordon  
11. BIRTHPLACE OF FATHER Utah  
12. MAIDEN NAME OF MOTHER Anna Jensen  
13. BIRTHPLACE OF MOTHER Neb-  
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
15. Filed May 21 1921  
Local Registrar W. Young

MEDICAL CERTIFICATE OF DEATH  
16. DATE OF DEATH May 20 1921  
17. I HEREBY CERTIFY, That I attended deceased from 19 to 19  
that I last saw him alive on 19  
and that death occurred on the date stated above, at M.  
The CAUSE OF DEATH\* was as follows:  
Hillborn  
Contributory Mitral Eclampsia  
(Signed) W. L. Wright M. D.  
(Address) Pocatello, Ida  
\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.  
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death yrs. mos. days. In the State yrs. mos. days.  
Where was disease contracted if not at place of death?  
Former or usual residence  
19. PLACE OF BURIAL OR REMOVAL Mountain View  
20. UNDERTAKER Edman & Son  
DATE OF BURIAL May 22 1921  
ADDRESS Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.*; *Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

JUN 13 1921

## CERTIFICATE OF DEATH

S

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 34143

Registered No. 41

## 1. PLACE OF DEATH

County of Barnesville Registration District No. 73  
City of Idaho Falls Primary Registration District No. 2190  
(No. \_\_\_\_\_) (St. \_\_\_\_\_)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Siltz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDMale White Infant  
(Write the word.)

## 6. DATE OF BIRTH

May 4 1921  
(Month) (Day) (Year)

## 7. AGE

Still Born  
IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Idaho Falls

## 10. NAME OF FATHER

J.B. Siltz Jr.

## 11. BIRTHPLACE OF FATHER

(State or Country)

Mont.

## 12. MAIDEN NAME OF MOTHER

Leatha Hawerton

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J.B. Siltz Jr.  
(Address) Idaho FallsFiled May 7 19 21 Atkinson  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 4 19 21  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 4 19 21, to May 4 19 21, that I last saw him alive on May 4 19 21, and that death occurred on the date stated above, at 6:00 M.

The CAUSE OF DEATH\* was as follows:

Still Born  
Mother had Pneumonia  
following measles  
(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. H. Siltz M. D.5/4/21 (Address) Idaho Falls

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Labell, Id.

## DATE OF BURIAL

5/4/21

## 20. UNDERTAKER

B. B. Woodward

## ADDRESS

Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## 1. PLACE OF DEATH

## CERTIFICATE OF DEATH

County of Cassia

Registration District No. ....

City of BurleyRegistration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Farnsworth

Cooper  
State of Idaho  
**BOARD OF HEALTH**  
Bureau of Vital Statistics  
File No. 34190  
Registered No. 303  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

## 6. DATE OF BIRTH.

## 7. AGE

IF LESS than 1 day how many .... hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

May 15 1921 D. J. Patterson  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

April 20 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

April 20 1921 to April 20 1921  
that I last saw ~~him~~ him Dead 1921

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

Lama During Birth

(Duration) Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) Yrs. .... mos. .... ds.

(Signed) J. H. Cooper M. D.19. (Address) Burley, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death .... yrs. .... mos. .... days, State .... yrs. .... mos. .... days

Where was disease contracted  
if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Reagan's Hill Cemetery April 21 1921

## 20. UNDERTAKER

## ADDRESS

R. W. Matt Burley, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED  
MAY 20 1921  
BUREAU OF VITAL STATISTICS

2-251  
A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles, Whooping cough, Chronic valvular heart disease, Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or 5 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1921

Local Registrar

## RECEIVED CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

34460

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Signed)

1921 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS



A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.*; *Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

18913

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED

JUN 30 1921

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Cassia*

City of *Burley*

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

Registration District No. *117*

STATISTICS

Registration District No. *2196*

(No. *Stillborn* St.)

2. FULL NAME

*Infant Mills*

*Patterson*  
State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *34510*  
Registered No. *217*  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

*M*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write in words.)

6. DATE OF BIRTH.

*May 7 1921*  
(Month) (Day) (Year)

7. AGE

*—* Yrs. *—* Mos. *—* ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*Edward Mills*

11. BIRTHPLACE OF FATHER

(State or Country)

*Utah*

12. MAIDEN NAME OF MOTHER

*Lapine Spencer*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Ed. Mills*

(Address)

*Burley*

15.

Filed *May 10 1921*

*D. J. C. Patterson*

Local Registrar.

16. DATE OF DEATH

*May 9 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*191* to *191*

that I last saw h. .... alive on *191*

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

*J. C. Patterson*

*5-10-21* (Address) *Burley, Ida.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days, In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

*Massachusetts Cemetery*

20. UNDERTAKER

*Keweenaw*

DATE OF BURIAL

*May 9 1921*

ADDRESS

*Burley*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible, to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 8-20-11. **RECEIVED** **JUL 5 1921** **BUREAU OF VITAL STATISTICS** **CERTIFICATE OF DEATH**

1. PLACE OF DEATH. Registration District No. 9  
County of Ada Primary Registration District No. 9  
City of Boise (St.)

File No. 34532  
Registered No. 34532  
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Infant Son H.E. Dayton

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Infant  
(Write the word.)

6. DATE OF BIRTH June 11 1921  
(Month) (Day) (Year)

7. AGE still born IF LESS than 1 day  
how many ..... hrs. or  
..... yrs. .... mos. .... ds. .... min.?

8. OCCUPATION —

9. BIRTHPLACE Boise Ida  
(State or Country)

10. NAME OF FATHER H. E. Dayton

11. BIRTHPLACE OF FATHER Kansas  
(State or Country)

12. MAIDEN NAME OF MOTHER Laura Loop

13. BIRTHPLACE OF MOTHER Stratton nebr  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs Carl Hankins  
(Address) Emmett Ida

15. Filled 6/13 1921 J. D. Reynolds  
Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH June 11 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1921, to June 11 1921  
that I last saw h..... alive on June 11 1921,  
and that death occurred on the date stated above, at 8:30 A. M.  
The CAUSE OF DEATH\* was as follows:  
Still born  
(Duration) ..... yrs. .... mos. .... ds.  
Contributory (Secondary) .....  
(Signed) R. H. Cunningham M. D.  
6/11 1921 (Address) Emmett  
State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,  
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death ..... yrs. .... mos. .... ds. State ..... yrs. .... mos. .... ds.  
Where was Disease contracted, If not at place of death?  
Former or usual residence.....  
19. PLACE OF BURIAL OR REMOVAL Emmett Ida DATE OF BURIAL 6/12 1921  
20. UNDERTAKER W. J. Buchanan ADDRESS Emmett Idaho

DATA  
REC  
DATE  
TIME

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory."

1895

RECEIVED

AUG 5 1921

BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

S

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 34626

Registered No. 195

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Adams

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

F

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.) Single

## 6. DATE OF BIRTH

July 8

(Month)

(Day)

1921 (Year)

## 7. AGE

Stillborn

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Boise

## 10. NAME OF FATHER

Walter Williams

## 11. BIRTHPLACE OF FATHER

(State or Country)

Mass

## 12. MAIDEN NAME OF MOTHER

Marie Adams

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Boise Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm McBratney  
Boise Idaho

## 15. Filed

July 8 1921

R. H. Pratt  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

7 (Month)

8 (Day)

1921 (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

July 8 1921, to July 8 1921

that I last saw her alive on never to

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still born caused by long difficult labor

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. Allen Greenway M. D.

1921

(Address)

Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Morris Hill Cem

7/8 1921

## 20. UNDERTAKER

## ADDRESS

W McBratney  
Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada Registration District No. 2  
City of Boise Primary Registration District No. 1004  
St. Lewis (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
AUG 5 1921  
BUREAU OF VITAL STATISTICS

2. FULL NAME

Baby Leonard

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 34631  
Registered No. 200

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male W. Single  
(Write the word.)

6. DATE OF BIRTH

July 14, 1921  
(Month) (Day) (Year)

7. AGE

Still Born. IF LESS than 1 day how many \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Charles E Leonard

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Gilliland

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm McBratney  
(Address) Boise Idaho

15.

Filed July 15, 1921 R. N. Pratt  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 14 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 14 1921, to July 14 1921  
that I last saw him alive on same 1921

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) M. Allen Queney M. D.

1921 (Address) Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

DATE OF BURIAL

7/15 1921

20. UNDERTAKER

W McBratney

ADDRESS,

Boise Idaho



A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

RECEIVED  
AUG 3 1921  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34841 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *S*  
Registered No. \_\_\_\_\_

1. PLACE OF DEATH *French*  
County of *Blaine* Registration District No. *102*  
City of *Blaine* (No. \_\_\_\_\_) (St.) \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Steel Barne*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-OWED OR DIVORCED  
(Write the word.)

6. DATE OF BIRTH *7* (Month) *25* (Day) *92* (Year)

7. AGE \_\_\_\_\_ IF LESS than 1 day how many \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*  
(State or Country)

10. NAME OF FATHER *Robert Stanger*

11. BIRTHPLACE OF FATHER  
(State or Country)

12. MAIDEN NAME OF MOTHER *Stella Ann Wecker*

13. BIRTHPLACE OF MOTHER *Idaho*  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Robert Stanger*  
(Address) *Idaho*

15. Filed *7/26* 19*21* *C. J. McPherson*  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *7* (Month) *25* (Day) *21* (Year)

17. I HEREBY CERTIFY That I attended deceased from *Steel Barne* 19*21*  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date stated above, at \_\_\_\_\_ M.  
The CAUSE OF DEATH\* was as follows:

*Pneumonia*

\_\_\_\_ (Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_

\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *C. J. McPherson* M. D.

*7/26/21* (Address) *Ashton, Id.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Griffard Idaho* *7.28.1921*

20. UNDERTAKER ADDRESS

*Lewis Kiser* *Ashton Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name or gin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. N.B.—In case of more than one child at birth a Separate Return must be made for each, and the number of each, in order of birth stated.

1. PLACE OF BIRTH  
County of Nez Perce  
City of \_\_\_\_\_  
No. \_\_\_\_\_ St. \_\_\_\_\_

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 34913

Registration District No. \_\_\_\_\_ State File No. \_\_\_\_\_

Prim. Registration District No. \_\_\_\_\_ Local Registrar's No. \_\_\_\_\_

(If born in hospital or institution give name.)

2. FULL NAME OF CHILD Chenorout

3. Sex	If plural births { 4. Twin, triplet, or other _____ 5. Number, in order of birth _____	6. Premature _____ Full term _____	7. Legiti- mate? _____	8. Date of birth <u>07/02</u> , 19 <u>21</u> (Month, Day, Year)
--------	---	---------------------------------------	---------------------------	--

9. Full name <u>Chenorout</u> FATHER	18. Full maiden name <u>Collins</u> MOTHER
---	---

10. Residence (usual place of abode) (If non-resident, give place and State) _____	19. Residence (usual place of abode) (If non-resident, give place and State) _____
---	---

11. Color or race _____	12. Age at last birthday _____ (years)	20. Color or race _____	21. Age at last birthday _____ (years)
-------------------------	--	-------------------------	--

13. Birthplace (city or place) (State or Country) _____	22. Birthplace (city or place) (State or Country) _____
--	--

OCCUPATION 14. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____ 15. Industry or business in which work was done, as silk mill, sawmill, bank, etc. _____ 16. Date (month and year) last engaged in this work _____, 19 _____ 17. Total time (years) spent in this work _____	OCCUPATION 23. Trade, profession, or particular kind of work done, as housekeeper, typist, nurse, clerk, etc. _____ 24. Industry or business in which work was done, as own home, lawyer's office, silk mill, etc. _____ 25. Date (month and year) last engaged in this work _____, 19 _____ 26. Total time (years) spent in this work _____
--	--

27. What prophylactic was used to prevent Ophthalmia Neonatorum? \_\_\_\_\_

28. Number of children of this mother (At time of this birth and including this child)  
(a) Born alive and now living \_\_\_\_\_ (b) Born alive but now dead \_\_\_\_\_ (c) Stillborn \_\_\_\_\_

29. If stillborn, period of gestation _____ { months or weeks	30. Cause of stillbirth _____ { Before labor _____ During labor _____
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ m. on the date above stated.  
(Born Alive or Stillborn)

(Signed) \_\_\_\_\_, M. D.

or \_\_\_\_\_, Midwife

Address \_\_\_\_\_

Filed \_\_\_\_\_, 193 \_\_\_\_\_

Registrar.

Registrar.

When there was no attending physician or midwife, then the father, householder, etc., should make this return.

Give name added from a supplemental report \_\_\_\_\_

(Date of)

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of NyeCity of Las Vegas

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Registration District No. 96Primary Registration District No. 1009(No. Stillborn St.)

S

File No. 34928Registered No. 674

If death occurred in a hospital, institution, or camp, give NAME, address, street and number.

RECEIVED  
AUG 11 1921

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

July  
(Month)11<sup>th</sup>  
(Day)1921  
(Year)

## 7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

Stillborn

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

R. R. Skinner

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Esmer Brown

(Address)

Las Vegas, N. M.

## 15.

Filed July 11 1921Aug 3 - 21  
Ernest E. Brown  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

July 11<sup>th</sup> 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

1921 to July 10 1921that I last saw him alive on 1921and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1921 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Las Vegas

## DATE OF BURIAL

7/12 1921

## 20. UNDERTAKER

Las Vegas Undertaking Co.

## ADDRESS

Las Vegas, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
Filed *34979*  
Registered No. *329*

## 1. PLACE OF DEATH

Registration District No. *2*  
County of *Bonne* Primary Registration District No. *1044*  
City of *Bonneville* *Washington* St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *African* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*  
(Write the word.)

## 6. DATE OF BIRTH

*Aug 6 1921*  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many..... hrs.  
or..... min.?  
Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

*none*

## 9. BIRTHPLACE

(State or Country)

*Bonne*

## 10. NAME OF FATHER

*Robert G. Clemens*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Vie*

## 12. MAIDEN NAME OF MOTHER

*Sarah Campbell*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Vie*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *R. M. Clemens*

(Address)

*Bonne Ida*

## 15.

Filed *August 8 1921*Local Registrar *R. H. Root*

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Aug 6 1921*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....  
that I last saw her alive on 19.....  
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

*Removal from return dead*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*E. C. Callahan* M. D.

19..... (Address).....

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Auburn Virginia* *8/9 1921*

## 20. UNDERTAKER

## ADDRESS

*Schreiber & Sidenfaden* *Bonne*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



FORM V. S. No. 5-25 M. 1-19.

RECEIVED

## CERTIFICATE OF DEATH

**S** State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. **35027**  
 Registered No. **111**

1. PLACE OF DEATH

AUG 27 1921

Registration District No. **73**County of **Bonner**

BUREAU OF VITAL

Registration District No. **2116**City of **Idaho Falls**(No. **New Sweden** St.)

If death occurs away from  
 usual residence, give facts  
 called for under special in-  
 formation.

2. FULL NAME

**Infant Robinson**

If death occurred in a hos-  
 pital, institution or camp,  
 give its NAME instead of  
 street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED**Female****White****Single**

(Write the word.)

6. DATE OF BIRTH

**Apr. 7****21****1921**

(Month)

(Day)

(Year)

7. AGE

**Born dead.**

IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or  
particular kind of work.**no.**(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)

9. BIRTHPLACE

(State or Country)

**near Idaho Falls Id.**10. NAME OF  
FATHER**Clarence Robinson**11. BIRTHPLACE  
OF FATHER

(State or Country)

**Mo.**12. MAIDEN NAME  
OF MOTHER**Goldie Buey**13. BIRTHPLACE  
OF MOTHER

(State or Country)

**Kansas**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**Clarence Robinson**

(Address)

**Idaho Falls Id.**

15.

Filed

**July 12 1921****W. F. Fennell**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

**Apr. 7****1921**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

**4-7-1921** to **4-7-21** 19

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

**Still born.**

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

**P. C. Hallister**

M. D.

19

(Address)

**Idaho Falls, Id.**

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted  
 if not at place of death?

Former or  
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

**Ron Hill****Mar 7 1921**

20. UNDERTAKER

ADDRESS

**Gifford Hayes****Idaho Falls**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

1891-9

## CERTIFICATE OF DEATH

**S** State of Idaho  
**BOARD OF HEALTH**  
 Bureau of Vital Statistics  
 File No. \_\_\_\_\_  
 Registered No. 1-3

## 1. PLACE OF DEATH

County of Bonner Registration District No. 73  
 City of Idaho Falls Primary Registration District No. 215-0  
Spencer Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

## BUREAU OF VITAL STATISTICS

## 2. FULL NAME

Infant Gullixson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single  
 (Write the word.)

## 6. DATE OF BIRTH

Apr. 23 1921  
 (Month) (Day) (Year)

## 7. AGE

Born dead,  
 Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

no.

## 9. BIRTHPLACE

(State or Country)

Idaho Falls

## 10. NAME OF FATHER

Chas. Gullixson

## 11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

## 12. MAIDEN NAME OF MOTHER

Laura Forthgill

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Gullixson  
 (Address) Idaho Falls Id.

## 15.

Filed July 4 1921 W. K. Kinnison  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Apr. 23 1921  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-23-1921, to 4-23-1921  
 that I last saw him alive on 4-23-1921,  
 and that death occurred on the date stated above, at 9 PM.  
 The CAUSE OF DEATH\* was as follows:

died immediately after being born.

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

J. D. Hollister  
Idaho Falls, Id.

19. 21 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Rose Hill

## 20. UNDERTAKER

Cliff Haines

## DATE OF BURIAL

Apr. 23, 1921

Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

157-2-

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

Registration District No.

City of

Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

S

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs. or  
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Born Dead

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. R. Mason M. D.

19. (Address) Kellogg, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days, State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

139-1

FORM V. S. No. 5-25 M. 1-19.

REC OCT 5 1921

BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Ada  
City of BoiseRegistration District No. 2Primary Registration District No. 1004  
(No. 410 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Elizabeth BurrusState of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 35113  
Registered No. 273

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDFemale White Single  
(Write the word.)

## 6. DATE OF BIRTH

Sept. 24 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Boise

## 10. NAME OF FATHER

Thomas H. Burrus

## 11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

## 12. MAIDEN NAME OF MOTHER

Mary Helen Morgan

## 13. BIRTHPLACE OF MOTHER

(State or Country)

N. York

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Burrus

(Address)

Caldwell Ida

## 15.

Filed Sept 26 1921R. H. Pratt  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sept 24 1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 24 1921, to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

still birth(Duration) Yrs. mos. ds.  
Contributory Large heart & child small  
(Secondary) poorly of mother

(Duration) Yrs. mos. ds.

(Signed) L. P. McCall M. D.7/26/1921 (Address) Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Johns Cemetery 7/26 1921

## 20. UNDERTAKER ADDRESS

Shelton & Widdowson Boise

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death); 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17  
SEP 19 1921  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH  
County of Idaho  
City of Shoshone  
If death occurs away from usual residence, give facts called for under special information.  
2. FULL NAME B. B. Devine

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 35389  
Registered No. ....  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male  
4. COLOR OR RACE White  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)  
6. DATE OF BIRTH Feb 7 1891  
7. AGE 30 Yrs. .... Mos. .... ds.  
IF LESS than 1 day how many .... hrs. or min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE  
(State or Country) Idaho

10. NAME OF FATHER J. C. Devine

11. BIRTHPLACE OF FATHER  
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER Mary Winkle

13. BIRTHPLACE OF MOTHER  
(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mary Devine  
(Address) Shoshone

15. Filed Aug 5 1921  
A. A. Newberry  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 7 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1921 to Aug 7 1921  
that I last saw him on Aug 7 1921  
and that death occurred on the date stated above, at 11:55 AM.

The CAUSE OF DEATH\* was as follows:  
Prunafur  
fatal birth  
(Duration) Yrs. .... mos. .... ds.

Contributory (Secondary)  
(Duration) Yrs. .... mos. .... ds.  
(Signed) F. A. Newberry M. D.  
Aug 8 1921 (Address) Shoshone Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days, State .... yrs. .... mos. .... days

Where was disease contracted  
If not at place of death?

Former or usual residence

19. PLACE OF BIRTH OR REMOVAL Shoshone DATE OF BURIAL Aug 9 1921

20. UNDERTAKER E. E. Duke ADDRESS Shoshone

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers, who receive a definite salary*) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

151-2

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson Registration District No. 15  
City of Rigby Primary Registration District No. 2176  
BUREAU OF VITAL STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No. S35589  
Registered No. 79

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single  
(Write the word.)

6. DATE OF BIRTH May 26 1921  
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day  
Yrs. Mos. ds. how many. hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho  
(State or Country)

10. NAME OF FATHER W.A. Westergard

11. BIRTHPLACE OF FATHER Utah  
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Childers

13. BIRTHPLACE OF MOTHER Utah  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.A. Westergard  
(Address) Rigby, Idaho

15. Filed 10/10 1921 Ray H Fisher  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
19. to 19.  
that I last saw him alive on 19.  
and that death occurred on the date stated above, at 11:30 P.  
The CAUSE OF DEATH\* was as follows:

(Duration) Yrs. mos. ds.  
Contributory (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) A.M. Palmer M. D.  
5/27/21 (Address) Rigby, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.  
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rigby DATE OF BURIAL 5/27 1921  
20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## 1. PLACE OF DEATH

County of *Blaine*City of *Tetchum*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Registration District No. *57*Primary Registration District No. *2022*(No. *57*)

(St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *S 35848*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

*12-1*19 *21**R. H. Wright*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 *21*  
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 *21* to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH was as follows:

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19..... (Address) *H. H. Hutton*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Tetchum, Idaho*

10-29-21

20. UNDERTAKER

ADDRESS

*R. S. Harris**Hailey.*

2

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

189-6

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

NO BC

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH

Onith  
State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **S 35975**  
Registered No. **550**

1. PLACE OF DEATH. **RECEIVED**  
County of **Cassia** Registration District No. **117**  
City of **Burley** Primary Registration District No. **2196**  
If death occurs away from usual residence, give facts called for under special information.  
2. FULL NAME **Infant Blindee**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**  
(Write the word.)

6. DATE OF BIRTH. **Oct 31 1921**  
(Month) (Day) (Year)

7. AGE **1** IF LESS than 1 day how many hrs. or min. **1**  
Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE **Idaho**  
(State or Country)

10. NAME OF FATHER **Nels O. Blindee**

11. BIRTHPLACE OF FATHER **Idaho**  
(State or Country)

12. MAIDEN NAME OF MOTHER **Moore**

13. BIRTHPLACE OF MOTHER **Idaho**  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Mrs. G. Blindee**  
(Address) **Burley Ida**

15. Filed **Nov 1 1921** **D. J. Patterson**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 31 1921**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 31 1921** to **Oct 31 1921**  
that I last saw h. — alive on — 1921  
and that death occurred on the date stated above, at — M.  
The CAUSE OF DEATH\* was as follows:

**Premature Birth**

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Signed) **J. R. Smith** M. D.  
19/31 1921 (Address) **Burley Idaho**

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Pleasant View Cemetery** DATE OF BURIAL **Oct 31 1921**

20. UNDERTAKER **R. W. Mott** ADDRESS **Burley Idaho**

2

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

151

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

no 36



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

**S** State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. **36030**

1. PLACE OF DEATH

County of **Fremont.**City of **Teton Idaho.**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

**Still Born.**

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

**Female.**

4. COLOR OR RACE

**White-**5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

**November 13** 19**21**  
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs.  
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

**Teton Idaho.**

10. NAME OF FATHER

**Raymond C? Berry**

11. BIRTHPLACE OF FATHER

(State or Country)

**Topeka Kansas.**

12. MAIDEN NAME OF MOTHER

**Daisy M. Woods.**

13. BIRTHPLACE OF MOTHER

(State or Country)

**Danerville Ill.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

**Raymond C. Berry**

(Informant)

**Teton Idaho**

(Address)

15.

Filed **11-15** 19**21** **Chapman**  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

**11 - 13** 19**21**  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

**11-13** 19**21**, to **11-13** 19**21**.

that I last saw h. **Stillborn** 19**21**.

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH\* was as follows:

**Macerated foetus  
 due to Strangled cord**

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

**11-15** 19**21** (Address) **Reynolds Ida**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

**Ashton Idaho**

DATE OF BURIAL

**11/15/21**

20. UNDERTAKER

**Lewis Kiser . Ashton Idaho.**

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

152-2

1. PLACE OF DEATH **RECEIVED** **CERTIFICATE OF DEATH.**  
 County of **Idaho** Registration District No. **49**  
 City of **near Kamaid** Primary Registration District No. **421**  
**BUREAU OF VITAL STATISTICS** File No. **36111**  
 Registered No. **36111**  
 If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Wilson**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **Indian** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**  
 (Write the word.)

6. DATE OF BIRTH. **Nov 5 1921**  
 (Month) (Day) (Year)

7. AGE **Stillborn** IF LESS than 1 day how many.....hrs. or.....min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE **Idaho**  
 (State or Country)

10. NAME OF FATHER **Michel Wilson**

11. BIRTHPLACE OF FATHER **Oregon**  
 (State or Country)

12. MAIDEN NAME OF MOTHER **May Allen**

13. BIRTHPLACE OF MOTHER **Idaho**  
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) **Nez Pence**  
 (Address)

15. **11/5 1921** **CJ Johnson**  
 Filed Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Nov 5 1921**  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 4 1921**, to **Nov 5 1921**, that I last saw him alive on **Nov 4 1921**, and that death occurred on the date stated above, at **2 P.M.** The CAUSE OF DEATH\* was as follows:

**Stillborn**

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) **W. Taylor** M. D.

19. (Address) **W. Taylor, Idaho**

\*State the DISEASE CAUSING DEATH; or indicate from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

**Ind. Cem. Kamaid Id** **Nov 5 1921**

20. UNDERTAKER ADDRESS

**CJ Johnson** **Kamaid Id**

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

69-1  
**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MAKING RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED  
DEC 18 1921  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

**S** State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 36283  
Registered No.

1. PLACE OF DEATH  
County of *Franklin* District No. *37*  
City of *Idaho Falls* Registration District No. *1085*  
(No. ) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Myrtle Smith*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*  
*(Write the word.)*

16. DATE OF DEATH  
*Nov 15 1921*  
(Month) (Day) (Year)

6. DATE OF BIRTH  
*Nov 15 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *11/18* 19*21*, to *19*  
that I last saw her alive on *11/18*  
and that death occurred on the date stated above, at *11* A.M.

7. AGE *0* Yrs. *0* Mos. *0* ds.  
IF LESS than 1 day how many hrs. or min.?

The CAUSE OF DEATH\* was as follows:  
*Still born*  
*Transverse presentation*

8. OCCUPATION  
(a) Trade, profession or particular kind of work. *Subject*  
(b) General nature of industry, business or establishment in which employed (or employer).

(Duration) Yrs. mos. ds.  
Contributory (Secondary)  
(Duration) yrs mos. ds.  
(Signed) *C. D. Weaver* M. D.  
(Address) *Twin Falls, Ida.*

9. BIRTHPLACE *Idaho*  
(State or Country)

10. NAME OF FATHER *Elmer Smith*

11. BIRTHPLACE OF FATHER *Calif*  
(State or Country)

12. MAIDEN NAME OF MOTHER *Alva Lewis*

13. BIRTHPLACE OF MOTHER *Wash*  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Mrs W S Lewis*  
(Address) *Jerome Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death yrs. mos. days. In the State yrs. mos. days.  
Where was disease contracted if not at place of death?  
Former or usual residence

15. Filed *Nov 19* 19*21* *John J. Coughlin*  
Local Registrar

19. PLACE OF BURIAL OR REMOVAL *Jerome Idaho* DATE OF BURIAL *Nov 15 1921*  
20. UNDERTAKER *F. E. DeWitt* ADDRESS *Twin Falls*

189-6

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

36324

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

Registration District No.

Primary Registration District No.

(No.)

St.)

File No.

Registered No.

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or  
particular kind of work.(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF  
FATHER11. BIRTHPLACE  
OF FATHER

(State or Country)

12. MAIDEN NAME  
OF MOTHER13. BIRTHPLACE  
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him on  
and that death occurred on the date stated above, at  
The CAUSE OF DEATH was as follows:

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted  
if not at place of death?Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Bannock*City of *Paris*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *28*Primary Registration District No. *6th*(No. *440*)

St.)

File No. *46*Registered No. *3710*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Duane Goodwin*

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX *Male*4. COLOR OR RACE *White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH *Dec 8 - 1921*

(Month)

(Day)

(Year)

7. AGE *Premature Birth*

IF LESS than 1 day

how many.....hrs.

or.....min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE *Idaho*

(State or Country)

10. NAME OF FATHER *Edwin C. Goodwin*11. BIRTHPLACE OF FATHER *Idaho*

(State or Country)

12. MAIDEN NAME OF MOTHER *Eva Wright*13. BIRTHPLACE OF MOTHER *Idaho*

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Duane Goodwin*(Address) *Paris, Idaho*15. Filed *12/8* *1921*Local Registrar *W. H. Young*16. DATE OF DEATH *Dec 8*

(Month)

(Day)

19 *21* (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 5* 19 *21* to *Dec 8* 19 *21*that I last saw him alive on *Dec 5* 19 *21*and that death occurred on the date stated above, at *6:19* M.

The CAUSE OF DEATH was as follows:

*Heart Failure*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. H. Young*

M. D.

19 *21* (Address) *Paris, Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Marquette, Mich*DATE OF BURIAL *Dec 7 1921*20. UNDERTAKER *W. H. Young*ADDRESS *Paris, Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

36335

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Bannock  
City of BozatlleRegistration District No. 28  
Primary Registration District No. 2161  
(No. Bozatlle St.)File No. 46  
Registered No. 3716If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

## 2. FULL NAME

Infant Yananaka

S

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE Japanese 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED Infant  
(Write the word.)

## 6. DATE OF BIRTH

December 12, 1921  
(Month) (Day) (Year)

## 7. AGE

StillbornIF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work.  
(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)Infant

## 9. BIRTHPLACE

(State or Country) Bozatlle, Ida.10. NAME OF  
FATHERHikoichi Yananaka11. BIRTHPLACE  
OF FATHER(State or Country) Japan12. MAIDEN NAME  
OF MOTHEROtsuichi Yokota13. BIRTHPLACE  
OF MOTHER(State or Country) Japan

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Man A. Bird  
(Address) Bozatlle15. 12/13 1921  
FiledJ. P. Young  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

December 12, 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Dec 12, 1921 to Dec 12, 1921  
that I last saw him alive on 12/12 1921  
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Still born -  
(blue baby?)

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

12/13/21 (Address) Bozatlle\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted  
if not at place of death?Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Mountain View

## DATE OF BURIAL

12/13/21

## 20. UNDERTAKER

Bozatlle

## ADDRESS

Bozatlle

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

36346

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Bannock  
City of PocatelloRegistration District No. 28  
Primary Registration District No. 2161  
(No. 505 So 12th St.)File No. 46  
Registered No. 3727

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Ward

S

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDMale White Infant  
(Write the word.)

6. DATE OF BIRTH

December 23, 1921  
(Month) (Day) (Year)

7. AGE

Stillborn  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country) Pocatello

10. NAME OF FATHER

Perrey J Ward

11. BIRTHPLACE OF FATHER

(State or Country) Idaho no

12. MAIDEN NAME OF MOTHER

Vera Cole

13. BIRTHPLACE OF MOTHER

(State or Country) Fairfax Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Perrey J Ward  
(Address) Pocatello15. 12/24 1921

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 23, 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to ..... 19.....

that I last saw h..... alive on..... 19.....,

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

baby was still born. Probably had been dead for 4 days.  
(Duration) Yrs. mos. ds.Contributory (Secondary) none

(Duration) Yrs. mos. ds.

(Signed) Dr. J. M. D.(Address) Pocatello Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View Cem Dec 24, 1921

20. UNDERTAKER ADDRESS

Schumacher & Hall Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

**S** State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. **36356**  
 Registered No. **132**

## 1. PLACE OF DEATH

County of **Bonneville**City of **Idaho Falls**

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. **73**Primary Registration District No. **2150**

BUREAU OF VITAL STATISTICS

## 2. FULL NAME

**Baby Gray - Still Born**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

**Male**

## 4. COLOR OR RACE

**White**

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

**Infant**  
(Write the word.)

## 6. DATE OF BIRTH

**Dec**  
(Month)**27**  
(Day)**1921**  
(Year)

## 7. AGE

**0** Yrs. **0** Mos. **0** ds.

IF LESS than 1 day

how many..... hrs.

or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

**Idaho Falls**

## 10. NAME OF FATHER

**Leroy Gray**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Utah**

## 12. MAIDEN NAME OF MOTHER

**Ruby Swan**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Utah**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**Leroy Gray**

(Address)

**Idaho Falls, Ida**

## 15.

Filed

**1/4**

19

**22**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Dec**  
(Month)**27**  
(Day)**1921**  
(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19..... to

19.....

that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

**Stillborn**

(Duration)

Yrs.....

mos.....

ds.....

Contributory  
(Secondary)

(Duration)

yrs.....

mos.....

ds.....

(Signed)

**H. J. Spencer** M. D.

19.....

(Address)

**Idaho Falls, Ida**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days..... In the State..... yrs..... mos..... days.....

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

**Idaho Falls**

## DATE OF BURIAL

**12/29** 1921

## 20. UNDERTAKER

**Edmund Woodley**

## ADDRESS

**Idaho Falls**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



## CERTIFICATE OF DEATH

S

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 36369

Registered No. 119

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Robinson

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

male white

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Dec. 29 1921  
(Month) (Day) (Year)

## 7. AGE

Born dead  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho Falls Ida

## 10. NAME OF FATHER

Edward J Robinson

## 11. BIRTHPLACE OF FATHER

(State or Country)

Wise

## 12. MAIDEN NAME OF MOTHER

Margaret Smalley

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Col.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Edward J Robinson  
Idaho Falls

## 15.

Filed

Jan 4 1922

L. J. Robinson  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec 29 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillbirth

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

1922 (Address) Idaho Falls Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Roe Hill, Idaho Falls

## DATE OF BURIAL

Dec 19 21

## 20. UNDERTAKER

C. J. Hansen

## ADDRESS

Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

## CERTIFICATE OF DEATH

State of Idaho  
**CARD OF HEALTH**  
 Bureau of Vital Statistics  
 File No. **36381**  
 Registered No. **422**

## 1. PLACE OF DEATH

County of **Blairstown**City of **Hailey**

If death occurs away from usual residence, give facts called for under special information.

Registration District No. **57**Primary Registration District No. **2022**

(No. \_\_\_\_\_)

St. \_\_\_\_\_

2. FULL NAME **Betty Warren**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male**4. COLOR OR RACE **White**

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

**Nov. 19, 1921**  
 (Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

**Steelbom**

## 9. BIRTHPLACE

(State or Country)

**Idaho**

## 10. NAME OF FATHER

**John H. Warren**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Oklahoma**

## 12. MAIDEN NAME OF MOTHER

**Lizzie Warming**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Idaho**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(Address) **John H. Warren**

## 15.

Filed **Jan. 7, 1922****R. H. Wright**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

\_\_\_\_\_ 19\_\_\_\_\_  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19\_\_\_\_\_, to 19\_\_\_\_\_,

that I last saw him \_\_\_\_\_ alive on 19\_\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

\_\_\_\_\_ (Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) **A. H. Dutton**

M. D.

19\_\_\_\_\_ (Address) \_\_\_\_\_

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

**Hailey, Ida**

## DATE OF BURIAL

**11-21-1921**

## 20. UNDERTAKER

**R. D. Harris**

## ADDRESS

**Hailey**

FEB 27 1979

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

11013

## 1. PLACE OF DEATH

**SPRINGFIELD**  
County of **Tremont.**

City of **Drummond**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Still Born. Nyborg.**

## CERTIFICATE OF DEATH

Registration District No. **103**Primary Registration District No. **6**

(No. .... St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **36595**

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

**December 29. 1921**

(Month) (Day) (Year)

7. AGE

IF LESS than 1 day

how many .... hrs.

or .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

**Drummond Idaho.**

(State or Country)

10. NAME OF FATHER

**Percy Nyborg.**

11. BIRTHPLACE OF FATHER

**Utah**

(State or Country)

12. MAIDEN NAME OF MOTHER

**Rhoda Foote**

13. BIRTHPLACE OF MOTHER

**Utah.**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Percy Nyborg.**(Address) **Drummond Idaho.**

15.

Filed **12-30-21**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

**December 29. 1921**

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

**Dec 29 1921 to Dec 29 1921**

that I last saw him alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

**Still Born.**

(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) **S. P. Haggan** M. D.(Address) **Ashtabula**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. .... yrs. .... mos. .... days. In the State. .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

**Wilford Idaho**

DATE OF BURIAL

**12/30/21**

20. UNDERTAKER

**Lewis Kiser Anton Ida**

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anagmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

No 5

FORM V. S. No. 5-25 M. 1-19

RECEIVED  
NOV 30 1921  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

(No.)

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 37957

Registered No. 15-

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

(Write the word.)

6. DATE OF BIRTH

Oct 21st

(Month)

(Day)

1921 (Year)

7. AGE

Still Born

Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Pioneerville

10. NAME OF FATHER

Cyrille Buntz

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake

12. MAIDEN NAME OF MOTHER

Mary Roun

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

File

Oct 26 1921

Mrs E S Rohsen

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 21

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pioneerville

Oct 26 1921

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated

492-223.003-812

PLACE OF BIRTH

St. Hall Indian Res.  
County of Bannock

STATE OF IDAHO  
Bureau of Vital Statistics  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-10m-8-7-11

**S 86620**

City of \_\_\_\_\_

Registration District No. 28

File No. 68

No. \_\_\_\_\_ St.

Primary Registration District No. 2161

Registered No. 3597

Hospital \_\_\_\_\_

FULL NAME OF CHILD Hornes Mice

Sex of Child <u>Female</u>	Twin, Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Jan. 23, 1921</u> (Month) (Day) (Year)
FATHER		MOTHER			
FULL NAME <u>Ichimatsu Mice</u>		FULL MAIDEN NAME <u>Fusa Yakayama</u>			
RESIDENCE <u>St. Hall Indian Reservation</u>		RESIDENCE <u>St. Hall Indian Reservation</u>			
COLOR <u>Japanese</u>	AGE AT LAST BIRTHDAY <u>46</u> (Years)	COLOR <u>Japanese</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)		
BIRTHPLACE <u>Japan</u>		BIRTHPLACE <u>Japan</u>			
OCCUPATION <u>Farming</u>		OCCUPATION <u>Housewife</u>			

Number of child of this mother, including present birth 2nd

Number of children, of this mother, now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Born dead at 9-P.M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Henry R. Wheeler  
Physician  
(Physician or Midwife)

Given names added from a supplemental report

Address Fort Hall, Idaho  
Filed 2-1-21  
J. Young  
Registrar

1000

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

## CERTIFICATE OF DEATH

32792  
State of IdahoBOARD OF HEALTH  
Bureau of Vital Statistics

File No. 37

Registered No. 3497

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 28  
County of Barnock Primary Registration District No. 441  
City of St. Hall Indian Reservation (No. \_\_\_\_\_) St. \_\_\_\_\_  
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Horuico Mise

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female Japanese Single  
(Write the word.)6. DATE OF BIRTH Jan 23 1921  
(Month) (Day) (Year)

7. AGE 0 yrs. 0 mos. 0 ds. IF LESS than 1 day how many 0 hrs. or min?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry business or establishment in which employed (or employer)

(At home)

9. BIRTHPLACE 1½ miles from St. Hall, Idaho.  
(State or Country) St. Hall Reservation

10. NAME OF FATHER Ichimatsu Mise

11. BIRTHPLACE OF FATHER Japan  
(State or Country)

12. MAIDEN NAME OF MOTHER Fusa Yakayama

13. BIRTHPLACE OF MOTHER Japan  
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Ichimatsu Mise  
(Address) Fort Hall, Idaho15. Filed Jan 24 1921 J. Young  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 23 1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1921, to Jan 23 1921.  
She was born dead Jan 23 1921 that I last saw her alive on Jan 23 1921 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Still born at term of 9 months

(Duration) 9 yrs. 0 mos. 0 ds.

Contributory Bruise Labor and (Secondary) decurt of cord

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Henry R. Wheeler M. D.  
Jan 24 1921 (Address) Fort Hall, Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death yrs. mos. ds. State yrs. mos. ds.  
Where was disease contracted,  
If not at place of death?  
Former or  
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt View Cem. Jan 25 1921

20. UNDERTAKER ADDRESS

H. L. M. C. Han Pacatello,

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

1897  
2/16/10

469112-014-432

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of CanyonCity of CaldwellRegistration District No. 3

File No.

S 86750

No. \_\_\_\_\_ St.

Hospital MyrattPrimary Registration District No. 2005 Registered No. 13FULL NAME OF CHILD Mule Mason Morton

Sex of Child <u>male</u>	Twin Triplet or other? <u>1</u> and <u>1</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of Birth <u>Jan. 12</u> 19 <u>21</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

FATHER  
FULL NAME Wm Franklin MortonRESIDENCE Middletown - IdahoCOLOR white AGE AT LAST BIRTHDAY 37 (Years)BIRTHPLACE Pendleton, OregonOCCUPATION HardwareMOTHER  
FULL MAIDEN NAME Ethel E. Mc CabeRESIDENCE Middletown - IdahoCOLOR white AGE AT LAST BIRTHDAY 18 (Years)BIRTHPLACE Hallsville, OregonOCCUPATION HousewifeNumber of child of this mother, including present birth. 1 Number of children of this mother now living, including present birth. 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 6<sup>40</sup> A. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]

(Physician or midwife)

Given names added from a supplemental report.

19.

Address Caldwell, IdahoFiled Feb. 12 1921Registrar John G. Meyer

Registrar

THE NEW YORK PUBLIC LIBRARY  
ASTOR LENOX TILDEN FOUNDATION  
500 5TH AVENUE  
NEW YORK 17, N.Y.

07 017

100

五、

RECEIVED

TEA, TA 310

304,941,912

94300 / 1014

...that I attended the trial of this case.

TO THE HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES  
IN SENATE CHAMBERS, WASHINGTON, D. C.  
JANUARY 10, 1917.  
SIR:  
I have the honor to acknowledge the receipt of your letter of the 9th inst., and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

From [illegible] - a most [illegible] [illegible]

(Listed as employee)

早稻(粳稻)

**CONFIDENTIAL**

1947-1948

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK -- THIS IS A PERMANENT RECORD  
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
32836  
File No. 6  
Registered No.

1. PLACE OF DEATH  
County of Canyon  
City of Caldwell  
Registration District No. 3  
Primary Registration District No. 2005  
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Marton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

16. DATE OF DEATH Jan 12 1921  
(Month) (Day) (Year)

6. DATE OF BIRTH Jan 12 1921  
(Month) (Day) (Year)

7. AGE Yrs. Mos. ds.  
IF LESS than 1 day how many hrs. or min.?

17. I HEREBY CERTIFY, That I attended deceased from 19 to 1-12 1921  
that I last saw him alive on 19  
and that death occurred on the date stated above, at 6:40 AM.

8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

The CAUSE OF DEATH\* was as follows:  
Still born

9. BIRTHPLACE Idaho  
(State or Country)

(Duration) Yrs. mos. ds.  
Contributory (Secondary)

10. NAME OF FATHER W. F. Marton

(Duration) yrs. mos. ds.  
(Signed) J. H. Gue M. D.

11. BIRTHPLACE OF FATHER Oregon  
(State or Country)

1/12 1921 (Address) Caldwell 28

12. MAIDEN NAME OF MOTHER Ethel McCabe

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. BIRTHPLACE OF MOTHER Oregon  
(State or Country)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death yrs. mos. days. In the State yrs. mos. days

(Informant) W. F. Marton  
(Address) Middleton Ida

Where was disease contracted if not at place of death?

15. Filed Jan. 12 - 1921 John A. Meyer  
Local Registrar

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Middleton  
DATE OF BURIAL 1-12 1921

20. UNDERTAKER E. V. Beckham  
ADDRESS Caldwell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



493-104-014-395

## PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTHCounty of CanyonCity of Caldwell Ida.Registration District No. 3 File No. 86767No. 1408 Dearborn St.Primary Registration District No. 2005 Registered No. 30

Hospital \_\_\_\_\_

## FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate? <u>yes</u>	Date of Birth <u>Feb.</u> <u>4th</u> <u>1921</u> (Month) (Day) (Year)
--------------------------	---	-----	---	-------------------------------	--

FATHER  
FULL NAME Robert William Mitchell

RESIDENCE \_\_\_\_\_

Wilder Ida.COLOR White AGE AT LAST BIRTHDAY 33  
(Years)BIRTHPLACE Nebraska

OCCUPATION \_\_\_\_\_

FarmerMOTHER  
FULL MAIDEN NAME Elsie Gladys Linebaugh

RESIDENCE \_\_\_\_\_

Wilder Ida.COLOR White AGE AT LAST BIRTHDAY 28  
(Years)BIRTHPLACE Colorado

OCCUPATION \_\_\_\_\_

House-wifeNumber of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still-born, at 5:00 P.M.  
on the date above stated. (Born alive or stillborn)

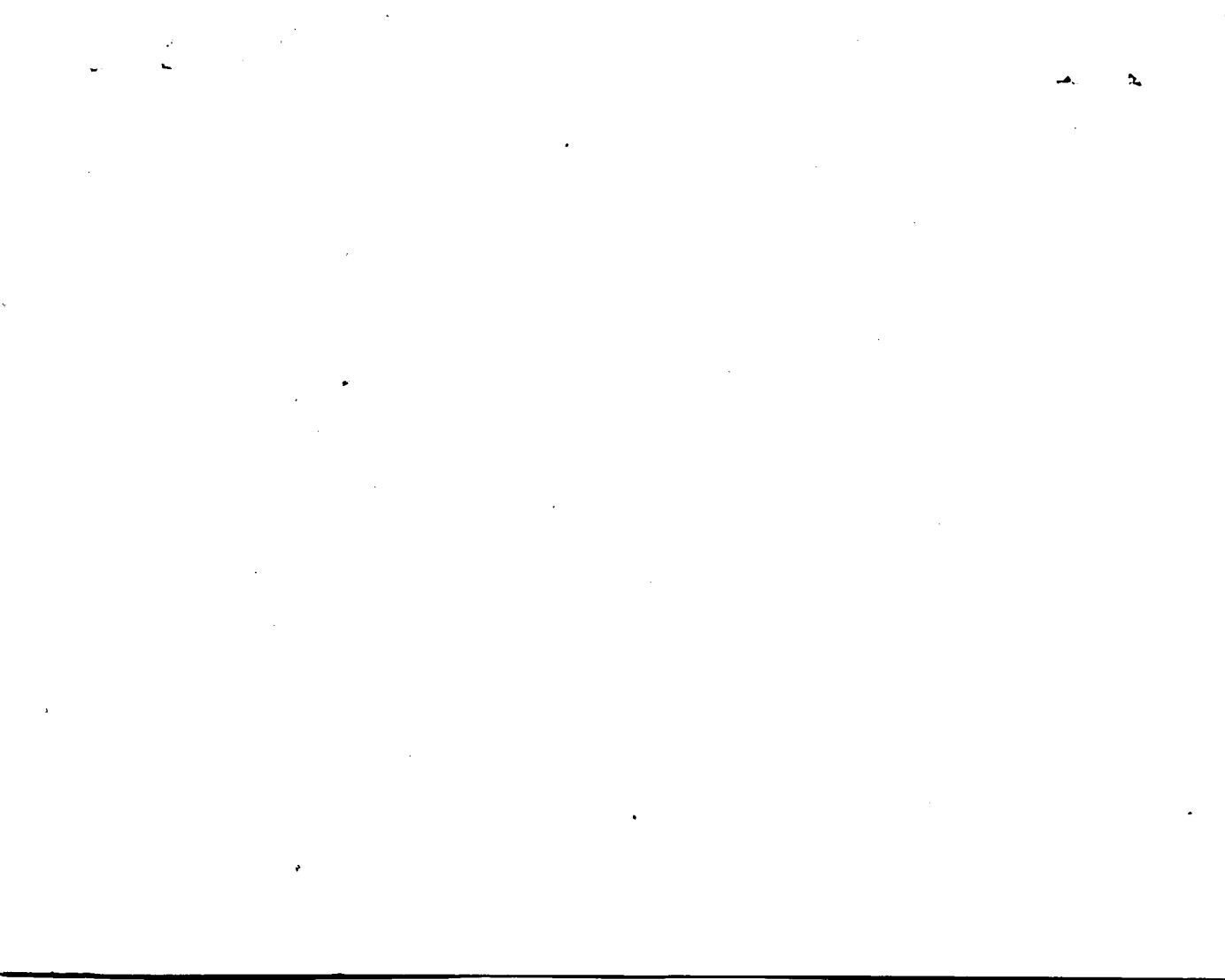
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. C. H. KaleyPhysician  
(Physician or midwife)

Given names added from a supplemental report.

19Address Caldwell Ida.Filed Feb. 5- 1921 John V. Meyer  
Registrar

Registrar



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## PLACE OF DEATH

County of *Canyon*Registration District No. *3*Primary Registration District No. *2005*File No. *32827*City of *Caldwell*

(No. \_\_\_\_\_ St.)

Registered No. *13*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Baby Mitchell*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

*male white* (Write the word.)

6. DATE OF BIRTH

*Jan 4 1921*  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min. ?  
\_\_\_\_ Yrs. \_\_\_\_ Mos. \_\_\_\_ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

*Caldwell*

10. NAME OF FATHER

*R. W. Mitchell*

11. BIRTHPLACE OF FATHER

(State or Country)

*Nebraska*

12. MAIDEN NAME OF MOTHER

*Elsie L. Firebaugh*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Colorado*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*R. W. Mitchell  
Wilder, Ida*

15.

Filed

*Feb. 5 1921 John L. Meyer*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Feb 4 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Feb. 4 1921 to Feb. 4 1921*  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_and that death occurred on the date stated above, at *5 P.* M.

The CAUSE OF DEATH\* was as follows:

*Stillborn  
due to mother falling against chair.*  
(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
(Secondary)

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

*M. L.aley* M. D.  
*Caldwell Ida*  
*2-5-1921* (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Canyon Hill* *2-5-1921*

20. UNDERTAKER

ADDRESS

*C. V. Beckham Caldwell*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

155-108-021-753  
PLACE OF BIRTHCounty of FranklinCity of Mink Creek

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Full Name of Child \_\_\_\_\_

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11—25m-6-15-18

## CERTIFICATE OF BIRTH

Registration District No. 2119 27File No. **S 86771**Primary Registration District No. 2/2119 Registered No. 22

SEX OF CHILD <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate? <u>yes</u>	DATE OF BIRTH <u>Jun 8 1927</u> (Month) (Day) (Year)
FATHER			MOTHER	
FULL NAME <u>Frank Geo. Jensen</u>			FULL MAIDEN NAME <u>Aida Geneva Peterson</u>	
RESIDENCE <u>Mink Creek</u>			RESIDENCE <u>Mink Creek</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)		COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Mink Creek</u>			BIRTHPLACE <u>Mink Creek</u>	
OCCUPATION <u>Farmer</u>			OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 7 A M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Allen R. Curtis

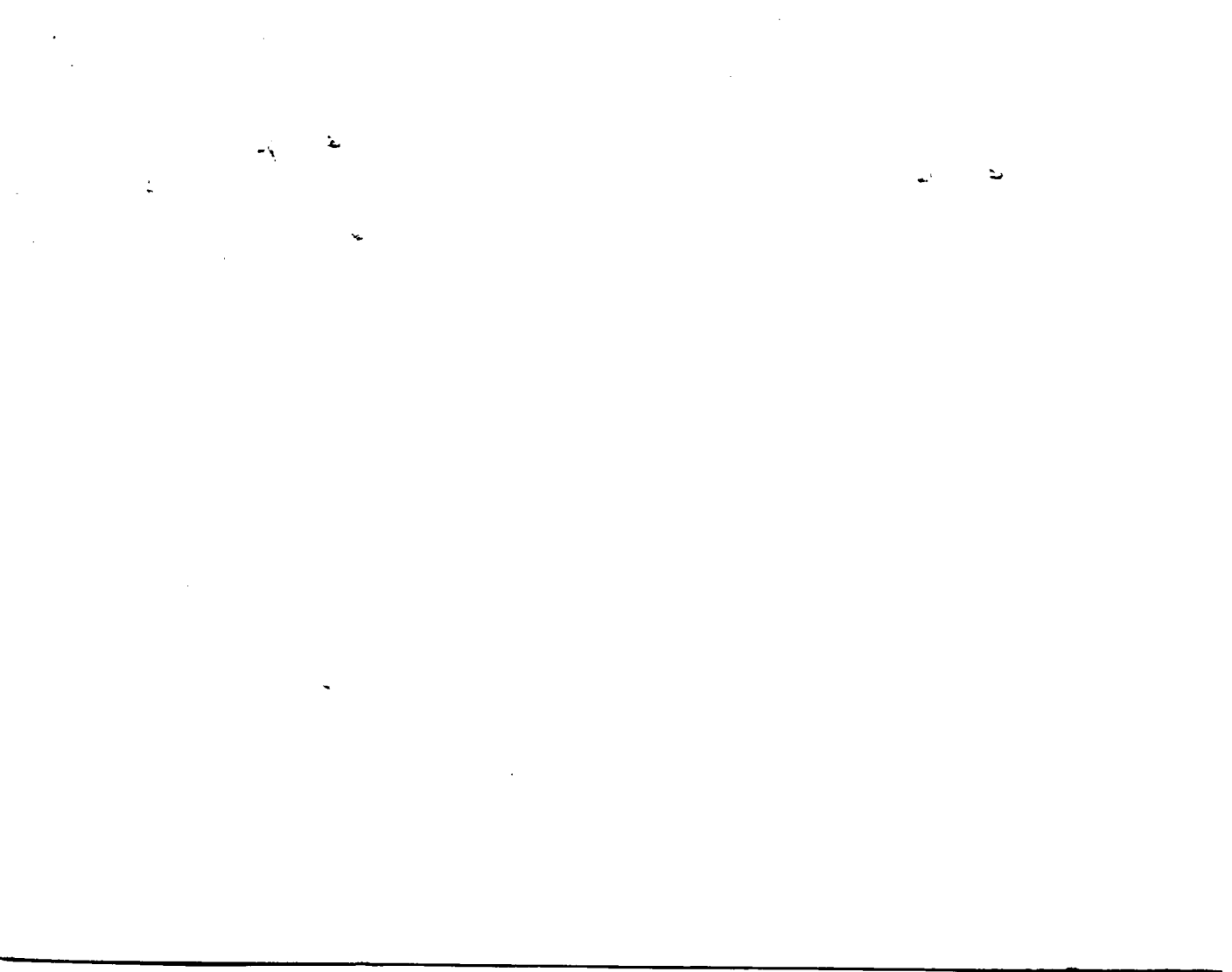
Given names added from a supplemental report

19

Address Preston, IdahoFiled Feb 7 19 21

Registrar

Registrar



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Franklin  
 City of Mark Creek

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2119-27  
 Primary Registration District No. 24 2119  
 (No. \_\_\_\_\_ St.)

## 2. FULL NAME

Stillborn

32853

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 3  
 Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word.)

6. DATE OF BIRTH

Jan. 8 1921  
 (Month) (Day) (Year)

7. AGE

Yrs. 1 Mos. 2 da. 1  
 IF LESS than 1 day how many 1 hrs. or 1 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. V  
 (b) General nature of industry, business or establishment in which employed (or employer). V

9. BIRTHPLACE

(State or Country) Mark Creek

10. NAME OF FATHER

Frank Lee Jones

11. BIRTHPLACE OF FATHER

(State or Country) Mark Creek

12. MAIDEN NAME OF MOTHER

Ada L. P. Jones

13. BIRTHPLACE OF MOTHER

(State or Country) Mark Creek

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Allen R. Butler  
Preston Idaho

(Address)

15.

Filed Feb. 2 1924 Allen R. Butler  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Not Known 19\_\_\_\_  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 8 1921, to Jan. 8 1921  
 that I last saw her alive on Not Known 19\_\_\_\_  
 and that death occurred on the date stated above, at Not Known

The CAUSE OF DEATH\* was as follows:

Cause Not Known

6 months gestation  
5 months development

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Allen R. Butler M. D.

24 1924 (Address) Preston Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

19\_\_\_\_

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



791-130-021-874

## PLACE OF BIRTH

County of FranklinCity of Preston

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Registration District No. 24927File No. S 86780Primary Registration District No. 27Registered No. 11Still born

Sex of Child

M.Twin  
Triplet  
or other?  
(To be answered only in event of plural births)and { Number  
in order  
of birthLegiti  
mate?yes.Date of  
BirthJan 30 1921  
(Month) (Day) (Year)FULL  
NAMEW<sup>m</sup> Frank Pratt

RESIDENCE

Preston Ida.

COLOR

W.AGE AT LAST  
BIRTHDAY43  
(Years)

BIRTHPLACE

Oxford Ida.

OCCUPATION

SalesmanFULL  
MAIDEN  
NAMEMattie Hadfield

RESIDENCE

Preston Ida.

COLOR

W.AGE AT LAST  
BIRTHDAY45  
(Years)

BIRTHPLACE

Smithfield Utah

OCCUPATION

HousewifeNumber of child of this mother, including present birth 8Number of children of this mother now living, including present birth 7

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

(Born alive or stillborn)

at 10:30 A. M.\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

Given names added from a supplemental report.

19

(Signature)

Albert R. Greer  
Physician  
(Physician or midwife)

Address

Preston Idaho

Filed

Feb. 7 1921D. R. C. C.

Registrar

Registrar



366.206.042-395

## PLACE OF BIRTH

County of Twin Falls.City of Claver

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTHRegistration District No. 34

File No.

S  
87014Primary Registration District No. 2087

Registered No. \_\_\_\_\_

Loontjer

Sex of Child <u>Female</u>	Twin Triplet or other? <u>X</u> and {	Number in order of birth <u>X</u>	Legiti mate? <u>yes</u>	Date of Birth <u>Jan '6</u> 19 <u>21</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

FULL NAME FATHER Richard G. LoontjerRESIDENCE Claver, Idaho.COLOR White AGE AT LAST BIRTHDAY 25 (Years)BIRTHPLACE NebraskaOCCUPATION Farmer.FULL MAIDEN NAME MOTHER Julia LindaeRESIDENCE Claver Idaho.COLOR White AGE AT LAST BIRTHDAY 23 (Years)BIRTHPLACE Illinois.OCCUPATION Housewife.Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth none

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born, at 1:00 P.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. A. Irmen, M.D.Physician  
(Physician or midwife)

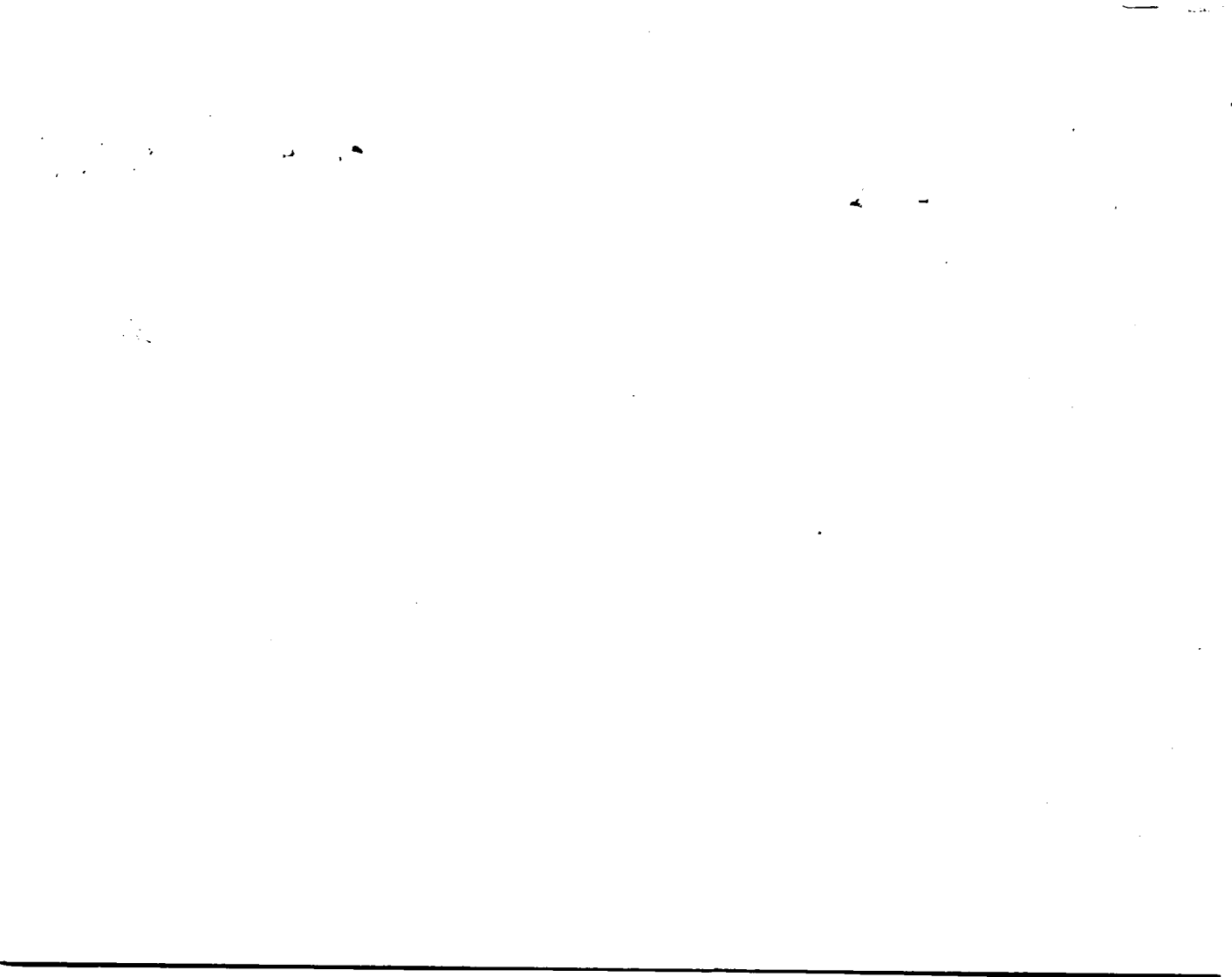
Given names added from a supplemental report.

19

Address Buhl IdahoFiled 1-14 1921

Registrar

Registrar J. A. Murphy



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH.  
County of Twin Falls.  
City of Claver Idaho

Registration District No. ....  
Primary Registration District No. 2087  
(No. .... St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 32925  
Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Loontjer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED. Single  
(Write the word.)

6. DATE OF BIRTH. Jan 6 1921  
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day  
how many ..... hrs. or  
..... Yrs. .... Mos. .... ds. .... min. none

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

none

9. BIRTHPLACE  
(State or Country) Claver Idaho

10. NAME OF FATHER Richard G. Loontjer

11. BIRTHPLACE OF FATHER  
(State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Julia Lindan

13. BIRTHPLACE OF MOTHER  
(State or Country) Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) F. A. Jrmew mll  
(Address) Buhl Idaho.

15.  
Filed 1-10 1921 J. H. Murphy  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 6 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191....., that I last saw h..... alive on Stillborn 191..... and that death occurred on the date stated above, at 1:00 P. M.

The CAUSE OF DEATH\* was as follows:

Still born.

(Prolonged labor, breech presentation)  
..... (Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

..... (Duration) ..... yrs. .... mos. .... ds.  
(Signed) F. A. Jrmew M. D.  
Jan 12 1921 (Address) Buhl Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cemetery, Claver Idaho DATE OF BURIAL Jan 12 1921

20. UNDERTAKER Buried by relatives ADDRESS Claver Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

655-2041042-253

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C--25m-7-21-19

County of Twin Falls

City of Buhl

No. - St.

Registration District No. 39

File No. **S 87015**

Primary Registration District No. 2087 Registered No.

Hospital

FULL NAME OF CHILD

Sex of Child <u>female</u>	<u>Twin</u> Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>1</u> / <u>4</u> / <u>1921</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------	-------------------------	---

FATHER  
FULL NAME L. Ray Overbaugh

RESIDENCE Buhl

COLOR white AGE AT LAST BIRTHDAY 26  
(Years)

BIRTHPLACE Iowa

OCCUPATION Carpenter

MOTHER  
FULL MAIDEN NAME Vera Bell

RESIDENCE Buhl

COLOR white AGE AT LAST BIRTHDAY 31  
(Years)

BIRTHPLACE Iowa

OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 11:20 a.m. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

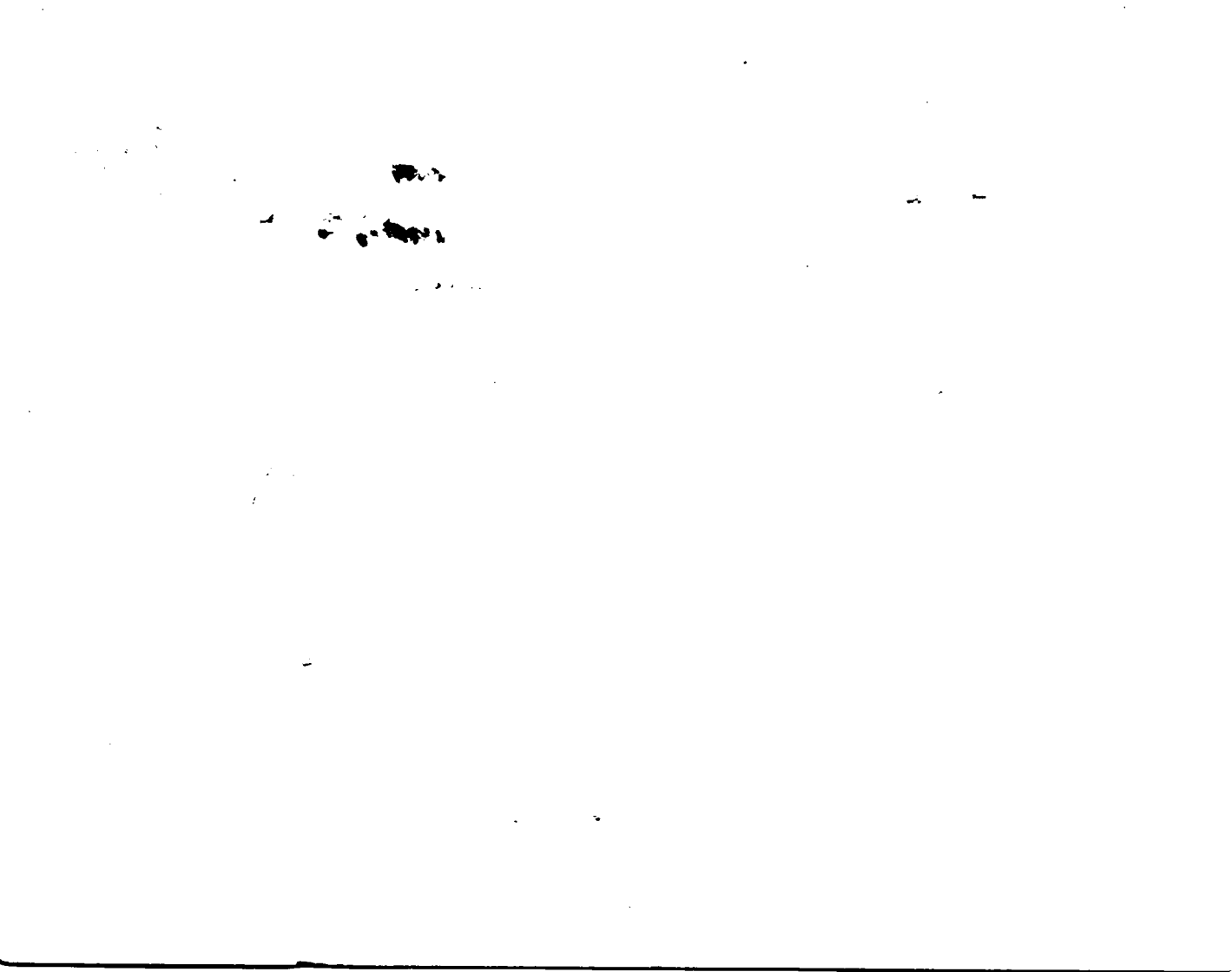
Given names added from a supplemental report.

(Signature) [Signature]  
(Physician or midwife)

Address Buhl  
Filed JAN 31 1921

Registrar

Registrar





## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

## 7. AGE

IF LESS than 1 day

how many hrs.

or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

Jan 4 1921

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

## 17. I HEREBY CERTIFY, That I attended deceased from

Jan 4 1921, to Jan 4 1921

that I last saw him alive on Jan 4 1921

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH\* was as follows:

Still born  
Placental separation  
(Duration) Yrs. mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Buhl Cemetery 1/4 1921

## 20. UNDERTAKER

## ADDRESS

Mawell &amp; Ruggs Buhl Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.* *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

286112.000-264  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-20m-7-28-19

CERTIFICATE OF BIRTH

**S 87073**

County of Ada

City of Boise

No. 1210 N. 16<sup>th</sup> St.

Registration District No. 9

File No. 87073

Hospital                     

Primary Registration District No. 1017 Registered No. 87

FULL NAME OF CHILD Baby Shook

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (of birth)	Legiti- mate? <u>Yes</u>	Date of Birth <u>2-12-1921</u> (Month) (Day) (Year)
--------------------------	---	-----	--	-----------------------------	--

FATHER		MOTHER	
FULL NAME <u>Samuel T. Shook</u>	FULL MAIDEN NAME <u>Maud Southward</u>	FULL NAME <u>Samuel T. Shook</u>	FULL MAIDEN NAME <u>Maud Southward</u>
RESIDENCE <u>1210 N. 16<sup>th</sup> St. Boise, Idaho</u>	RESIDENCE <u>1210 N. 16<sup>th</sup> St. Boise, Idaho</u>	RESIDENCE <u>1210 N. 16<sup>th</sup> St. Boise, Idaho</u>	RESIDENCE <u>1210 N. 16<sup>th</sup> St. Boise, Idaho</u>
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Nebraska</u>	BIRTHPLACE <u>Kansas</u>	BIRTHPLACE <u>Nebraska</u>	BIRTHPLACE <u>Kansas</u>
OCCUPATION <u>Thresher</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Thresher</u>	OCCUPATION <u>Housewife</u>

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 11:30 a. m.  
on the date above stated. before I arrived (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) T. N. Braxton  
(Physician or midwife)

Given names added from a supplemental report. 19

Address Boise, Idaho  
Filed Feb 25 1921 R. N. Palt  
Registrar.

85058

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Boise  
City of BoiseRegistration District No. 1004Primary Registration District No. 1210 N. 16th(No. 1210 N. 16th St.)Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Shook.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male white

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Feb 12 - 1921  
(Month) (Day) (Year)

## 7. AGE

Still Born  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Boise, Idaho

## 10. NAME OF FATHER

A. T. Shook

## 11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

## 12. MAIDEN NAME OF MOTHER

Maud Southward

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Hill City, Kansas

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm M. Bratney

(Address)

Boise, Idaho

## 15.

Filed

Feb 14 1921W. M. Bratney

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb 12 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Feb 12 1921 to Feb 12 1921  
that I last saw h. Still Born 19and that death occurred on the date stated above, at 11:30 AM

The CAUSE OF DEATH\* was as follows:

Filling of Lungs with  
greenish fluid before  
head was delivered(Duration) Yrs. mos. 10 min ds.Contributory  
(Secondary)Pulmonary atelectasis(Duration) yrs. mos. 5 min ds.

(Signed)

J. N. Bratney M. D.4/12/21 (Address) Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cemetery

## DATE OF BURIAL

2/12 1921

## 20. UNDERTAKER

W. M. Bratney

## ADDRESS

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

954-216001-613

## PLACE OF BIRTH

County of AdaCity of Bain

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital St. Alphonsus

FULL NAME OF CHILD

Registration District No. 2Primary Registration District No. 1004File No. 87079Registered No. 88

Sex of Child female { Twin Triplet or other? } and { Number in order of birth } Legiti mate? Yes Date of Birth Feb. 16 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FULL NAME Bert L. Reddington FATHERRESIDENCE Glenview, Id.COLOR White AGE AT LAST BIRTHDAY 24 (Years)BIRTHPLACE ColoradoOCCUPATION EngineerFULL MAIDEN NAME May Watkins MOTHERRESIDENCE Glenview, Id.COLOR White AGE AT LAST BIRTHDAY 19 (Years)BIRTHPLACE IdahoOCCUPATION HousewifeNumber of child of this mother, including present birth. 1 Number of children of this mother now living, including present birth. 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Feb. 16, 1921, at 9 a. m.  
on the date above stated. (live or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) For R. Numerus

(Physician or midwife)

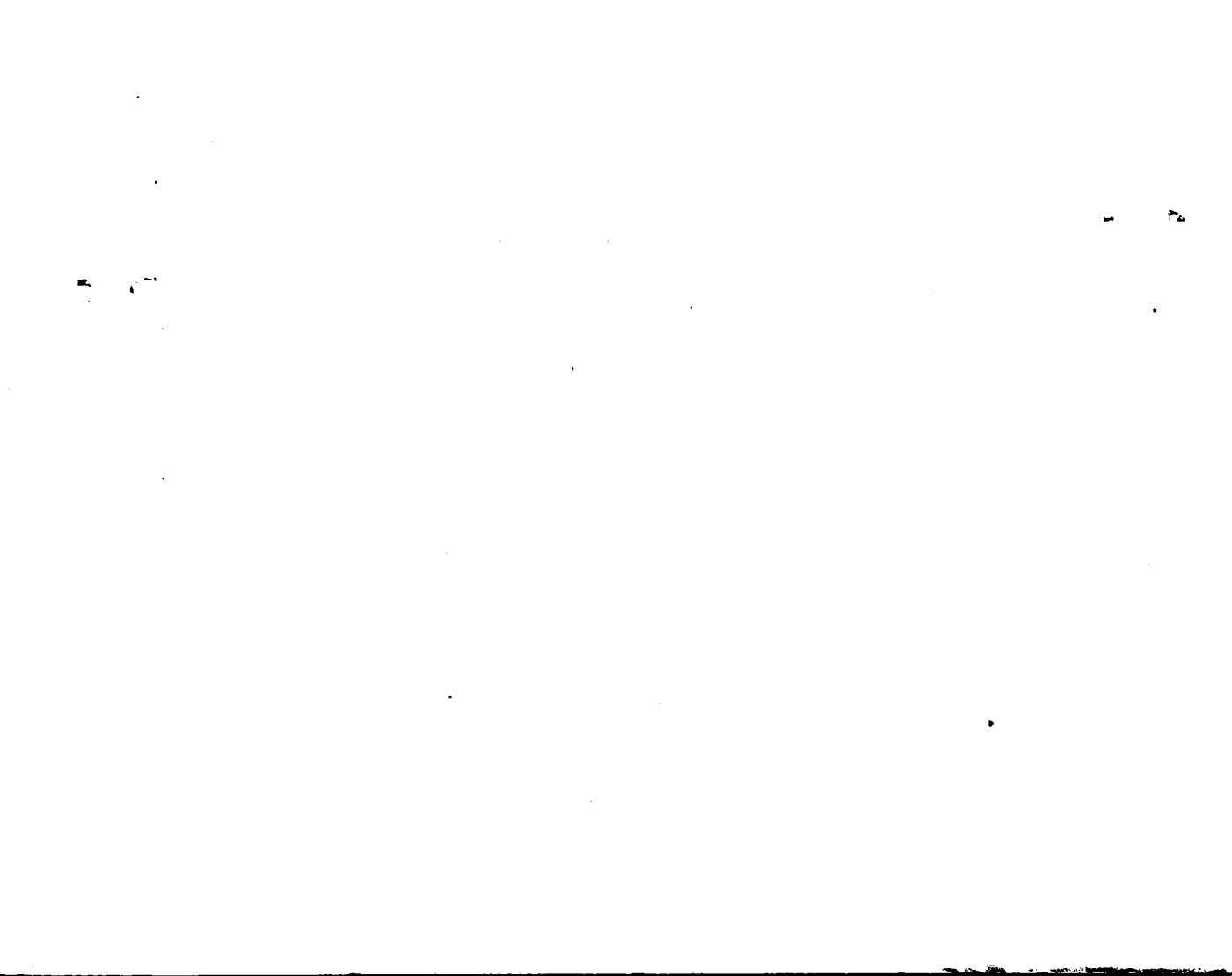
Given names added from a supplemental report.

19

Address Bain, IdahoFiled Feb. 25 1921

Registrar

Registrar R. H. Paddy





FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Ada  
 City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7Primary Registration District No. 1004(No. St. Alphonsus Hospital St.)

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 32954  
 Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

Baby Redington

## PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
Female White Single  
 (Write the word.)

6. DATE OF BIRTH Feb. 16, 1921  
 (Month) (Day) (Year)

7. AGE Still Born. IF LESS than 1 day  
 Yrs. Mos. ds. how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

None

## 9. BIRTHPLACE

(State or Country)

Boise, Idaho

## 10. NAME OF FATHER

Best Lee Redington

## 11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

## 12. MAIDEN NAME OF MOTHER

Mae Watkins

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm McBratney

(Address)

Boise, Idaho

15. Filed Feb 16, 1921 P. H. Pratt  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb 16, 1921  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16<sup>th</sup> 1921, to Feb 16 1921, that I last saw her alive on Feb 16 1921, and that death occurred on the date stated above, at — M. The CAUSE OF DEATH\* was as follows:  
Still born

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

7/16 1921 Jos. R. Newman M. D.  
 (Address) Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Monroe Hill Cemetery

2/16/21

## 20. UNDERTAKER

## ADDRESS

Wm McBratney

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

315-203-003-349  
PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH  
Form V. S. No. 11-C-25m-7-21-19  
MAR 10 1921  
S 87144  
69

County of Bannock

City of Paiceltlo

No. 356 So. 8<sup>th</sup> St.

Hospital Home

Registration District No. 28

File No. 69

Primary Registration District No. 2161

Registered No. 3614

FULL NAME OF CHILD

Sex of Child <u>female</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and	Number in order of birth <u>28</u>	Legiti mate? <u>yes</u>	Date of Birth <u>Feb. 3</u> 1921 (Month) (Day) (Year)
----------------------------	---	-----	------------------------------------	-------------------------	--

FATHER  
FULL NAME Samuel Lavers  
RESIDENCE 356 So. 2<sup>nd</sup> Ave  
COLOR White AGE AT LAST BIRTHDAY 28 (Years)  
BIRTHPLACE Italy  
OCCUPATION O.S.T. Bookmaker

MOTHER  
FULL MAIDEN NAME Maria Luzzato  
RESIDENCE 356 So. 2<sup>nd</sup> Ave  
COLOR White AGE AT LAST BIRTHDAY 26 (Years)  
BIRTHPLACE Italy  
OCCUPATION Housekeeping

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth one

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 10 4 M. on the date above stated. (Born alive or stillborn)

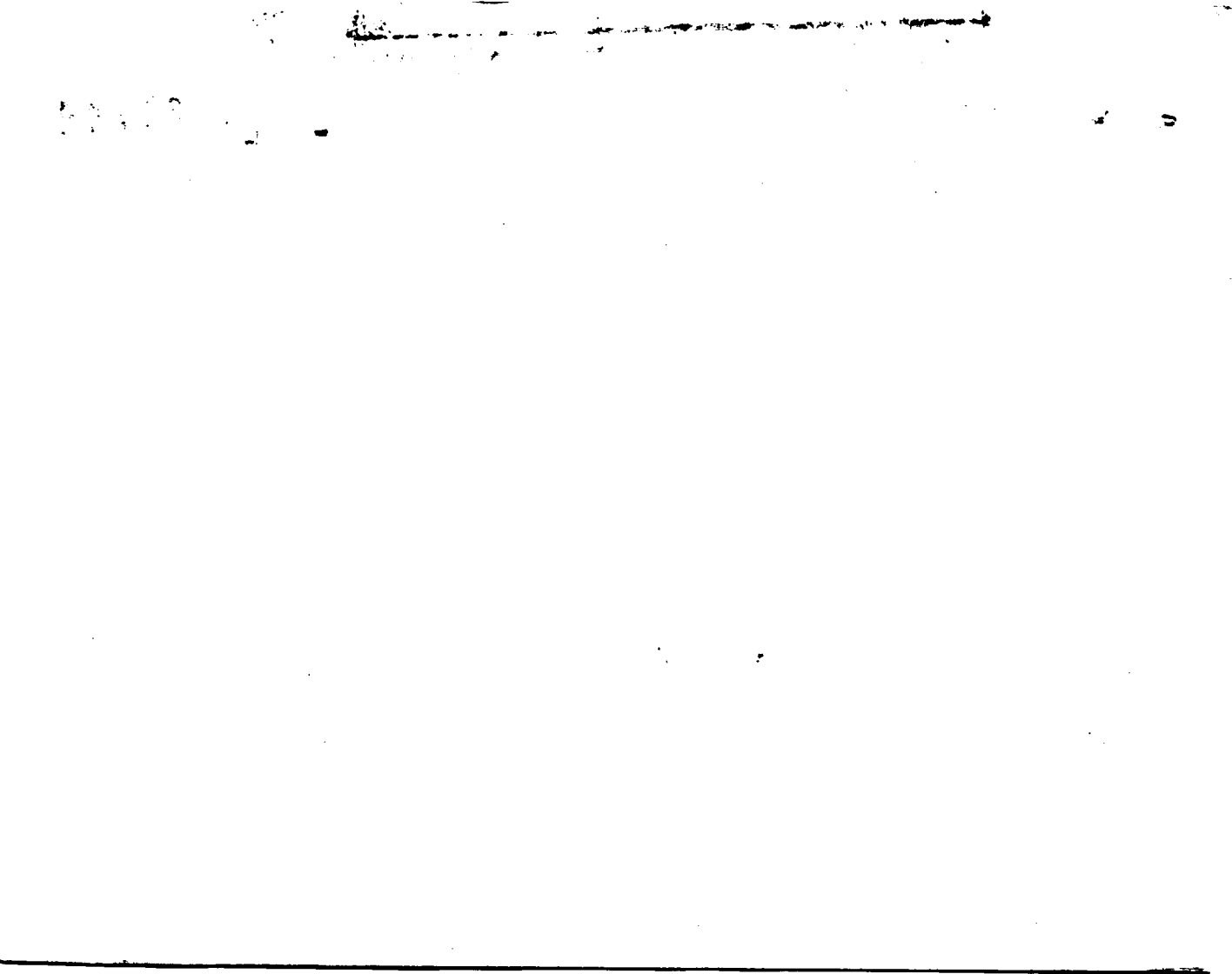
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mrs. Ann M. Bird  
Midwife  
(Physician or midwife)

Given names added from a supplemental report.

Address 413 So. 4<sup>th</sup> Ave  
Filed 3/1 1921  
Registrar J. J. Young

Registrar



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Barnock  
 City of Posinus

Registration District No. 28  
 Primary Registration District No. 2161  
 (No. 356 S. 2nd St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Favero

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 38  
 Registered No. 3506

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Italian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

## 6. DATE OF BIRTH

Feb 3 1921  
 (Month) (Day) (Year)

## 7. AGE

Two Years  
 Yrs. Mos. ds.

IF LESS than 1 day  
 how many yrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Thomas Favero

## 11. BIRTHPLACE OF FATHER

(State or Country)

Italy

## 12. MAIDEN NAME OF MOTHER

unknown

## 13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thomas Favero  
Posinus Idaho

## 15.

Filed 2/4 1921

W. J. Young  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb 3 1921  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

July 3 1921 to July 3 1921

that I last saw him alive on July 3 1921

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Mountain View Feb 5 1921

## 20. UNDERTAKER

## ADDRESS

Schumacher Bros City

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

613-202,005-962  
PLACE OF BIRTHSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form No. 10-10-17 No. 11-C-25m-9-8-15

County of BennettCity of St. MarisRegistration District No. 32

File No.

S 87195

No. \_\_\_\_\_ St.

Primary Registration District No. 2049

Registered No.

19

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Olive Emogene WaltersSex of Child femaleTwin  
Triplet  
or other?{ and { Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti-  
mate?yesDate of  
Birth321917

(Month)

(Day)

(Year)

FULL  
NAMEHarry Walters

FATHER

FULL  
MAIDEN  
NAMENeva Robertson

MOTHER

RESIDENCE

St. Maris, Ida

RESIDENCE

St Maris, Ida.

COLOR

whiteAGE AT LAST  
BIRTHDAY31  
(Years)

COLOR

whiteAGE AT LAST  
BIRTHDAY18  
(Years)

BIRTHPLACE

Ohio

BIRTHPLACE

Oregon

OCCUPATION

Fireman

OCCUPATION

house-wife

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE \*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

(Born alive or stillborn)

at 1:45 a.m.{ \* When there was no attending physician or  
midwife, then the father, householder, etc., should  
make this return. A stillborn child is one that  
neither breathes nor shows other evidence of life  
after birth.

(Signature)

Olive D. East

(Physician or midwife)

Given names added from a supplemental report.

19

Address

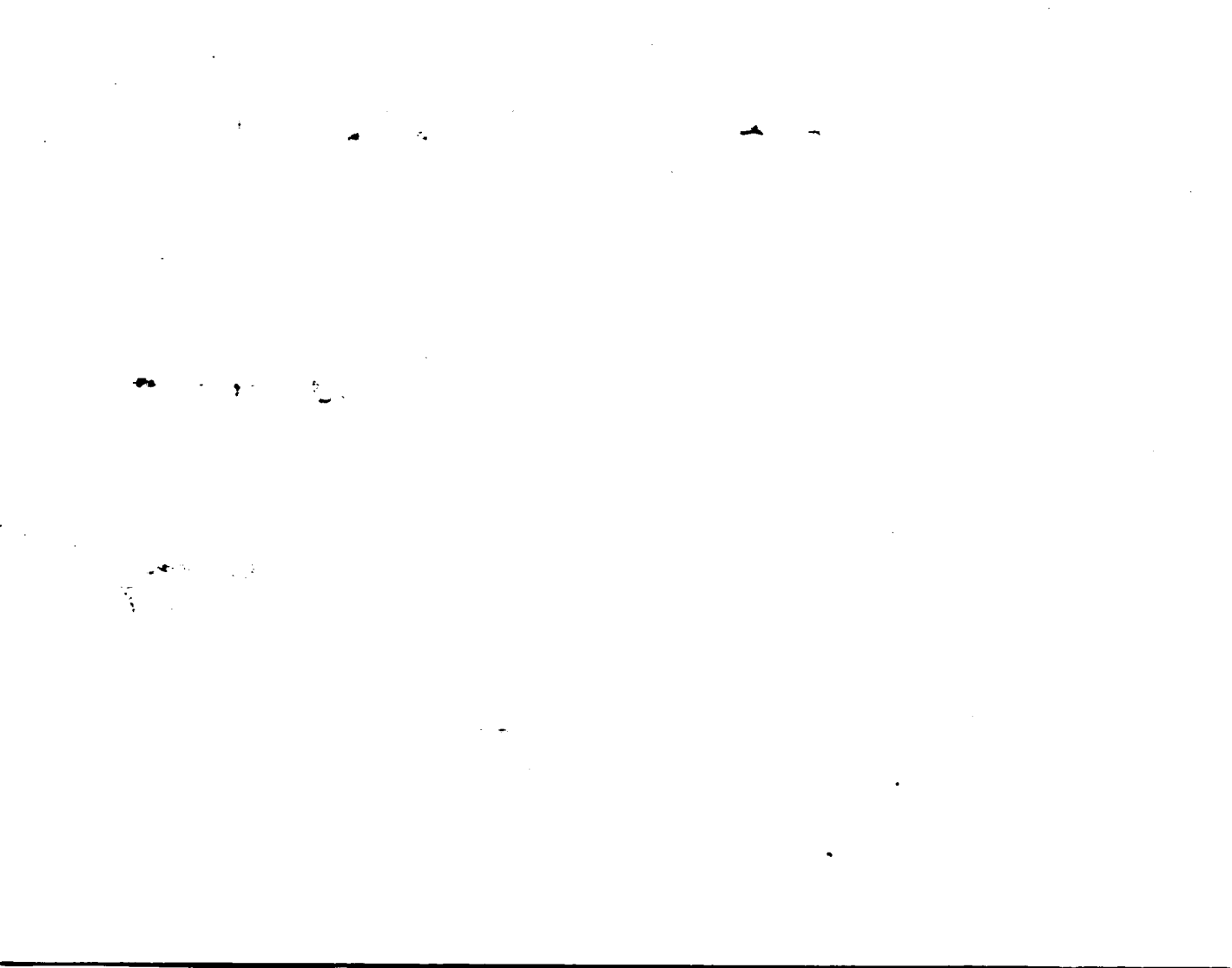
St. Maris

Filed

Mar 2 1921St. E. Hunt

Registrar

Registrar





## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bennett  
 City of St. Mari's Ida

Registration District No. 32  
 Primary Registration District No. 2049  
 (No. \_\_\_\_\_ St.)

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 33017  
 Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Olive Eugene Walters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED single  
 (Write the word.)

## 6. DATE OF BIRTH

3 2 1921  
 (Month) (Day) (Year)

## 7. AGE

still Born  
 Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work X  
 (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Harry Walters

## 11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

## 12. MAIDEN NAME OF MOTHER

Neva Robertson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Wright

(Address)

St. Mari's Ida

## 15.

Filed Mar 3 1921

H. E. Smith  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19  
 that I last saw h alive on 19  
 and that death occurred on the date stated above, at M.  
 The CAUSE OF DEATH\* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Owen O. Fleet M. D.

Feb 3 1921 (Address) St. Mari's Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Woodlawn

## DATE OF BURIAL

3-3 1921

## 20. UNDERTAKER

Mitchell & McLaughlin

## ADDRESS

St. Mari's

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

545229.006-599

PLACE OF BIRTH

County of Bingham

City of Blackfoot

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital Blackfoot General

FULL NAME OF CHILD

Registration District No. 121

Primary Registration District No. 1007

File No. S 87228

Registered No. 39

Ruth Emerson.

Sex of Child Female Twin Triplet or other? (To be answered only in event of plural births) and Number in order of birth Legiti mate? Yes Date of Birth Jan 29 1921 (Month) (Day) (Year)

FULL NAME FATHER Francis Earl Emerson

RESIDENCE Nielsen Montana

COLOR White AGE AT LAST BIRTHDAY 24 (Years)

BIRTHPLACE Minnesota

OCCUPATION Farming

FULL MAIDEN NAME MOTHER Emily Erickson

RESIDENCE Nielsen Montana

COLOR White AGE AT LAST BIRTHDAY 24 (Years)

BIRTHPLACE Minnesota

OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 10:30 a.m. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. W. Beck Physician (Physician or midwife)

Given names added from a supplemental report.

Address Blackfoot, Idaho Filed Jan 30 1921 Mrs. Helen E. Pattee Registrar

Registrar

~~CONFIDENTIAL~~ to whom?

City of



CHINA  
Set of

**MOTHER**

**RIGHTS**

1999

RECEIVED

SECRET

THE UNIVERSITY OF CHICAGO

# RAJO

100-443884-100

(b)(7)(C), (b)(7)(D)

SECRET

**304194 1946**

NOITAFUOZO

## NOTES

Number of child in household

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

1. I have a copy of the book "The History of the United States" by John Adams.

1. संस्कृत

[illegible]

~~James Earl Ray - FBI file - page 87(2)~~

4422

**Wages**

24. 12-12-46 - In case of more than one copy of a letter a cover sheet containing the following information must be attached to each copy and the original to be kept in a separate file. The cover sheet must be headed "RECEIVED" and "BY WHOM RECEIVED" and "DATE RECEIVED".

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

# CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bingham  
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 1007

(No. No Bingham Blackfoot)

## 2. FULL NAME

Ruth Emerson

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 33042  
Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

### 3. SEX

Female

### 4. COLOR OR RACE

White

### 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

### 6. DATE OF BIRTH

Jan 29 1921  
(Month) (Day) (Year)

### 7. AGE

Stillborn  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

### 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

None

### 9. BIRTHPLACE

(State or Country)

Blackfoot, Ida

### 10. NAME OF FATHER

Francis Earl Emerson

### 11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

### 12. MAIDEN NAME OF MOTHER

Emily Erickson

### 13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

### 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis E Emerson

(Address)

Helena Montana

### 15.

Filed

Jan 30 1921 Mr. Halim E. Patne  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

### 16. DATE OF DEATH

Stillborn Jan 29 1921  
(Month) (Day) (Year)

### 17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date stated above, at..... M.  
The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W W Beck M. D.

1/29/1921 (Address) Blackfoot, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

### 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

### 19. PLACE OF BURIAL OR REMOVAL

### DATE OF BURIAL

Grove City Cemetery Jan 30 1921

### 20. UNDERTAKER

### ADDRESS

Ed. A. Egli Blackfoot

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

214202-009271  
PLACE OF BIRTH

Form V. S. No. 11-C—25m-7-21-19  
STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

County of Bonner

City of PRIEST RIVER, IDAHO Registration District No. 65 File No. S87246

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital Priest River, Primary Registration District No. 2185 Registered No. 50

FULL NAME OF CHILD Ginio Sado

Sex of Child <u>Female</u>	<u>Twin</u> <u>Triplet</u> or other? (To be answered only in event of plural births)	and	<u>Number</u> in order of birth	Legitimate? <u>Yes</u>	Date of Birth <u>Feb. 2 1921</u> (Month) (Day) (Year)
----------------------------	---	-----	---------------------------------------	---------------------------	--

FULL NAME <u>Mike Sado</u>	FATHER
RESIDENCE <u>PRIEST RIVER, IDAHO</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>Italy</u>	
OCCUPATION <u>Laborer</u>	

FULL MAIDEN NAME <u>Susie Spanirelli</u>	MOTHER
RESIDENCE <u>PRIEST RIVER, IDAHO</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Italy</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born at 11.50 P.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) B. P. Getty M.D.

Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address PRIEST RIVER, IDAHO

Filed March 1 1921

Registrar

Registrar

SECRET

Registration District No. \_\_\_\_\_

1960-1961  
1962-1963  
1964-1965  
1966-1967  
1968-1969  
1970-1971  
1972-1973  
1974-1975  
1976-1977  
1978-1979  
1980-1981  
1982-1983  
1984-1985  
1986-1987  
1988-1989  
1990-1991  
1992-1993  
1994-1995  
1996-1997  
1998-1999  
2000-2001  
2002-2003  
2004-2005  
2006-2007  
2008-2009  
2010-2011  
2012-2013  
2014-2015  
2016-2017  
2018-2019  
2020-2021  
2022-2023  
2024-2025  
2026-2027  
2028-2029  
2030-2031  
2032-2033  
2034-2035  
2036-2037  
2038-2039  
2040-2041  
2042-2043  
2044-2045  
2046-2047  
2048-2049  
2050-2051  
2052-2053  
2054-2055  
2056-2057  
2058-2059  
2060-2061  
2062-2063  
2064-2065  
2066-2067  
2068-2069  
2070-2071  
2072-2073  
2074-2075  
2076-2077  
2078-2079  
2080-2081  
2082-2083  
2084-2085  
2086-2087  
2088-2089  
2090-2091  
2092-2093  
2094-2095  
2096-2097  
2098-2099  
2100-2101  
2102-2103  
2104-2105  
2106-2107  
2108-2109  
2110-2111  
2112-2113  
2114-2115  
2116-2117  
2118-2119  
2120-2121  
2122-2123  
2124-2125  
2126-2127  
2128-2129  
2130-2131  
2132-2133  
2134-2135  
2136-2137  
2138-2139  
2140-2141  
2142-2143  
2144-2145  
2146-2147  
2148-2149  
2150-2151  
2152-2153  
2154-2155  
2156-2157  
2158-2159  
2160-2161  
2162-2163  
2164-2165  
2166-2167  
2168-2169  
2170-2171  
2172-2173  
2174-2175  
2176-2177  
2178-2179  
2180-2181  
2182-2183  
2184-2185  
2186-2187  
2188-2189  
2190-2191  
2192-2193  
2194-2195  
2196-2197  
2198-2199  
2200-2201  
2202-2203  
2204-2205  
2206-2207  
2208-2209  
2210-2211  
2212-2213  
2214-2215  
2216-2217  
2218-2219  
2220-2221  
2222-2223  
2224-2225  
2226-2227  
2228-2229  
2230-2231  
2232-2233  
2234-2235  
2236-2237  
2238-2239  
2240-2241  
2242-2243  
2244-2245  
2246-2247  
2248-2249  
2250-2251  
2252-2253  
2254-2255  
2256-2257  
2258-2259  
2260-2261  
2262-2263  
2264-2265  
2266-2267  
2268-2269  
2270-2271  
2272-2273  
2274-2275  
2276-2277  
2278-2279  
2280-2281  
2282-2283  
2284-2285  
2286-2287  
2288-2289  
2290-2291  
2292-2293  
2294-2295  
2296-2297  
2298-2299  
2300-2301  
2302-2303  
2304-2305  
2306-2307  
2308-2309  
2310-2311  
2312-2313  
2314-2315  
2316-2317  
2318-2319  
2320-2321  
2322-2323  
2324-2325  
2326-2327  
2328-2329  
2330-2331  
2332-2333  
2334-2335  
2336-2337  
2338-2339  
2340-2341  
2342-2343  
2344-2345  
2346-2347  
2348-2349  
2350-2351  
2352-2353  
2354-2355  
2356-2357  
2358-2359  
2360-2361  
2362-2363  
2364-2365  
2366-2367  
2368-2369  
2370-2371  
2372-2373  
2374-2375  
2376-2377  
2378-2379  
2380-2381  
2382-2383  
2384-2385  
2386-2387  
2388-2389  
2390-2391  
2392-2393  
2394-2395  
2396-2397  
2398-2399  
2400-2401  
2402-2403  
2404-2405  
2406-2407  
2408-2409  
2410-2411  
2412-2413  
2414-2415  
2416-2417  
2418-2419  
2420-2421  
2422-2423  
2424-2425  
2426-2427  
2428-2429  
2430-2431  
2432-2433  
2434-2435  
2436-2437  
2438-2439  
2440-2441  
2442-2443  
2444-2445  
2446-2447  
2448-2449  
2450-2451  
2452-2453  
2454-2455  
2456-2457  
2458-2459  
2460-2461  
2462-2463  
2464-2465  
2466-2467  
2468-2469  
2470-2471  
2472-2473  
2474-2475  
2476-2477  
2478-2479  
2480-2481  
2482-2483  
2484-2485  
2486-2487  
2488-2489  
2490-2491  
2492-2493  
2494-2495  
2496-2497  
2498-2499  
2500-2501  
2502-2503  
2504-2505  
2506-2507  
2508-2509  
2510-2511  
2512-2513  
2514-2515  
2516-2517  
2518-2519  
2520-2521  
2522-2523  
2524-2525  
2526-2527  
2528-2529  
2530-2531  
2532-2533  
2534-2535  
2536-2537  
2538-2539  
2540-2541  
2542-2543  
2544-2545  
2546-2547  
2548-2549  
2550-2551  
2552-2553  
2554-2555  
2556-2557  
2558-2559  
2560-2561  
2562-2563  
2564-2565  
2566-2567  
2568-2569  
2570-2571  
2572-2573  
2574-2575  
2576-2577  
2578-2579  
2580-2581  
2582-2583  
2584-2585  
2586-2587  
2588-2589  
2590-2591  
2592-2593  
2594-2595  
2596-2597  
2598-2599  
2600-2601  
2602-2603  
2604-2605  
2606-2607  
2608-2609  
2610-2611  
2612-2613  
2614-2615  
2616-2617  
2618-2619  
2620-2621  
2622-2623  
2624-2625  
2626-2627  
2628-2629  
2630-2631  
2632-2633  
2634-2635  
2636-2637  
2638-2639  
2640-2641  
2642-2643  
2644-2645  
2646-2647  
2648-2649  
2650-2651  
2652-2653  
2654-2655  
2656-2657  
2658-2659  
2660-2661  
2662-2663  
2664-2665  
2666-2667  
2668-2669  
2670-2671  
2672-2673  
2674-2675  
2676-2677  
2678-2679  
2680-2681  
2682-2683  
2684-2685  
2686-2687  
2688-2689  
2690-2691  
2692-2693  
2694-2695  
2696-2697  
2698-2699  
2700-2701  
2702-2703  
27

APR 10 1964

[illegible]

NAME: Mrs. Mary  
FATHER: [illegible]  
MOTHER: [illegible]  
NAME: [illegible]  
FATHER: [illegible]  
MOTHER: [illegible]

RESIDENT

NAME	DATE AT LAST BIRTHDAY	COLOR	AGE AT LAST BIRTHDAY
White	1940	White	1940

SECRET

BIRTHPLACE

Y1411

10-10-60

10-10-68

1. The first group of people who are interested in the study of the history of the United States are the people who are interested in the history of the United States.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

1. I was born on 11/11/1911 in the city of New York, New York, and I am now residing in the city of New York, New York.

အကျဉ်းချုပ်

20. Attached is a copy of a letter dated 12/12/54 from the  
 21. Bureau to the New York Office regarding the above captioned  
 22. matter. A copy of this letter is also being furnished to the  
 23. New York Office for its information. Very truly yours,  
 24. Special Agent in Charge

[illegible]

**முதலாம்**

447

12/15/2011



## CERTIFICATE OF DEATH

1. PLACE OF DEATH  
County of **Bonner**  
City of **PRIEST RIVER, IDAHO**

Registration District No. **85**  
Primary Registration District No. **2185**  
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Ginio Sado**

33048  
State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. ....  
Registered No. **31**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **Single**  
(Write the word.)

6. DATE OF BIRTH

**Feb 2 1921**  
(Month) (Day) (Year)

7. AGE

**Still born**  
Yrs. Mos. ds.

IF LESS than 1 day  
how many ..... hrs.  
or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **None**  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

**Mike Sado**

11. BIRTHPLACE OF FATHER

(State or Country) **Italy**

12. MAIDEN NAME OF MOTHER

**Susie Spanirelli**

13. BIRTHPLACE OF MOTHER

(State or Country) **Italy**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mike Sado**

(Address) **PRIEST RIVER, IDAHO**

15.

Filed **Mar 1 1921**

Local Registrar **E. P. Jett**

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

**Feb 2 1921**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....  
that I last saw her alive on **not** ..... 19.....  
and that death occurred on the date stated above, at ..... M.  
The CAUSE OF DEATH\* was as follows:

**Still born**

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) **E. P. Jett** M. D.

**Feb 2 1921** (Address) **PRIEST RIVER, IDAHO**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL  
**PRIEST RIVER, IDAHO**

DATE OF BURIAL  
**Feb 4 1921**

20. **USE THIS FOR**

Father **Mike Sato**

ADDRESS

**PRIEST RIVER, IDAHO**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Hardware*; (a) *Foreman*, (b) *Automobile factory*. The material words may form part of the second statement. Never report "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home who are engaged in the duties of the household only and not paid *Housekeepers*, who receive a definite salary, may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

793-1291014-815

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of Canyon

City of ampa

Nb. 1720-2<sup>nd</sup> St No. St.

Registration District No. 7

File No. 87326

Hospital —

Primary Registration District No. 1006

Registered No. —

FULL NAME OF CHILD

Sex of Child male

Twin Triplet or other? — and — Number in order of birth —  
(To be answered only in event of plural births)

Legitimate? yes

Date of Birth Jan 21 1921  
(Month) (Day) (Year)

FATHER  
FULL NAME George Filant

RESIDENCE 1720-2<sup>nd</sup> St Noampa

COLOR White AGE AT LAST BIRTHDAY 46  
(Years)

BIRTHPLACE mo

OCCUPATION laborer

MOTHER  
FULL MAIDEN NAME Mary Hawk

RESIDENCE 1720-2<sup>nd</sup> St Noampa

COLOR White AGE AT LAST BIRTHDAY 41  
(Years)

BIRTHPLACE mo

OCCUPATION Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still Born, at 130a M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Leo W Chittor MD

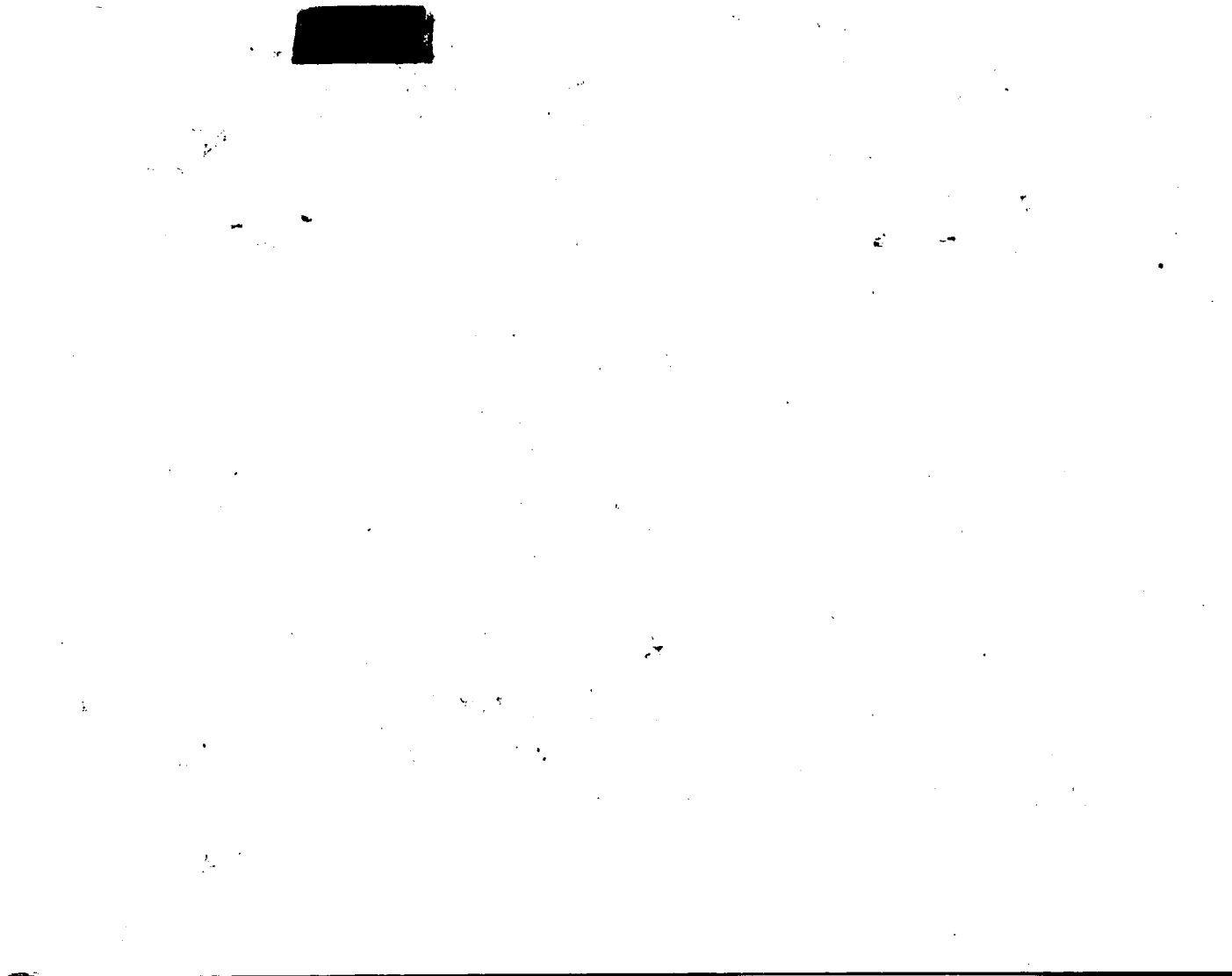
Given names added from a supplemental report.

(Physician or midwife)  
Address ampa Ida

Filed Feb. 10 1921 Pearle Dodder

Registrar

Registrar



## CERTIFICATE OF DEATH

MAR

## 1. PLACE OF DEATH

County of CanyonCity of Hamden

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7Primary Registration District No. 1006

(No. .... St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 33063

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

Infant Pleasant

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white (Write the word.)

6. DATE OF BIRTH

Jan 29 1921  
(Month) (Day) (Year)

7. AGE

✓ Yrs. ✓ Mos. ✓ ds.IF LESS than 1 day  
how many .... hrs.  
or .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George Pleasant

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Mary Hank

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Feb 10 1921 Pearl Dodde  
Filed Local Registrar

16. DATE OF DEATH

Jan 29 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 29 1921 to Jan 29 1921

that I last saw him alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Leo H Chilton M. D.2/10/21 (Address) Hamden Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL

Hamden

DATE OF BURIAL

29 1921

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH  
368-228-018-235  
County of *San Mateo*  
City of *San Bruno*  
Registration District No. ....  
No. .... *St.*  
Primary Registration District No. .... *2108*

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

**S** 87383  
File No. ....  
Registered No. .... *8*

Hospital .....

FULL NAME OF CHILD ..... *W. M. named*

Sex of Child <i>Female</i>	Twin Triplet or other? <input type="checkbox"/>	and { Number in order of birth (To be answered only in event of plural births) }	Legitimate? <i>Yes</i>	Date of Birth <i>Feb 28</i> (Month) (Day) (Year) <i>1911</i>
FULL NAME <i>James Edwin</i>	FATHER		FULL MAIDEN NAME <i>Ida</i>	MOTHER
RESIDENCE <i>San Bruno</i>	RESIDENCE <i>Ida</i>		RESIDENCE <i>San Bruno</i>	RESIDENCE <i>Ida</i>
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>31</i> (Years)		COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>30</i> (Years)
BIRTHPLACE <i>Idaho</i>	BIRTHPLACE <i>Idaho</i>		BIRTHPLACE <i>Idaho</i>	BIRTHPLACE <i>Idaho</i>
OCCUPATION <i>Lawyer</i>	OCCUPATION <i>Lawyer</i>		OCCUPATION <i>Housewife</i>	OCCUPATION <i>Housewife</i>

Number of child of this mother, including present birth..... *1* Number of children of this mother now living, including present birth..... *1*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was..... *born* at *3:30* a.m. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) ..... *J. M. Gandy*  
.....  
(Physician or midwife)

Given names added from a supplemental report.

Address ..... *San Bruno*  
Filed *Feb 28 1911*  
Registrar *J. M. Gandy*

10-55

記

## Introduction

SECRET

20-72011  
67-111

150-100  
100-100

YACHTING  
AGE AT LAST

TELETYPE  
YACHTING

1945

2024-07-17

**POSTAL SERVICE**

and the same is true of the other two.

.....now also, before and in front of the public in a public place.

in order to achieve the same result, the  
highest, and the lowest, and the middle  
level of the same result, and the middle  
level of the same result, and the middle

Source: *Journal of the American Medical Association*, 1964, 191:1281-1284.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 40

County of...

Primary Registration District No. 2168

City of...

(No. ...)

St. ...

Registered No. 33089

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

Baby John

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white

(Write the word.)

## 6. DATE OF BIRTH

Feb 28 1921  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

Feb 28 1921

Local Registrar

## 16. DATE OF DEATH

Feb 28 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1921 to Feb 28 1921

that I last saw him alive on Feb 28 1921

and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed)

M. D.

2/28/21 Address: Prof. S. S. S.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Prof. S. S. S.

Feb 28 1921

## 20. UNDERTAKER

## ADDRESS

Bob and Son

Prof. S. S. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

381-214-021-699

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Mar 10 1924 11-C-25m-7-21-19

County of FranklinCity of PrestonNo. 2nd Ward St.Registration District No. 2119File No. S 87438Hospital -Primary Registration District No. 27Registered No. 32FULL NAME OF CHILD Seiborn

Sex of Child <u>7</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>ye</u>	Date of Birth <u>Feb 14</u> 19 <u>24</u> (Month) (Day) (Year)
-----------------------	---	-----	--------------------------------	---------------------------	--

FULL NAME <u>William Alma Chapman</u>	FATHER
RESIDENCE <u>Preston, Idaho</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Verena Wright</u>	MOTHER
RESIDENCE <u>Preston, Idaho</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 9 Number of children of this mother now living, including present birth 6

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Curtis Hand  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Preston Idaho  
Filed Mar 2 19 21 D. M. Cull  
Registrar

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



MAR 10 1921

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Franklin  
City of PrestonRegistration District No. 2119Primary Registration District No. 27

(No. \_\_\_\_\_ St.)

File No. 33090Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Stillborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single  
(Write the word.)

6. DATE OF BIRTH

Feb 14 1921  
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day  
how many 0 hrs.  
or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William Alma Chapman

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Verena Wright

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm A Chapman

(Address)

Preston Idaho

15.

Filed Mar 3 1921 Dr A C Curtis  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 14 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 14 1921 to Feb 14 1921

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Asphyxiation due to retention of food - a result of a very short anterior-posterior diameter

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Curtis Rand M. D.1921 (Address) Preston Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

Preston Cemetery

DATE OF BURIAL

Feb 16 1921

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
 and the number of each, in order of birth stated.

792-127021-55  
 PLACE OF BIRTH

County of Franklin

City of Mustan

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

FULL NAME OF CHILD Pre-mature birth 5 month gestation

Sex of Child male Twin Triplet or other? \_\_\_\_\_ and { Number in order of birth 2 Legiti mate? yes Date of Birth Feb 27 1921  
 (To be answered only in event of plural births) (Month) (Day) (Year)

FULL NAME M M Kibbe  
 FATHER  
 RESIDENCE Mustan Idaho  
 COLOR white AGE AT LAST BIRTHDAY 24  
 (Years)  
 BIRTHPLACE Id  
 OCCUPATION Farmer

FULL MAIDEN NAME Amanda Jensen  
 MOTHER  
 RESIDENCE Mustan Idaho  
 COLOR white AGE AT LAST BIRTHDAY 21  
 (Years)  
 BIRTHPLACE Maytan Idaho  
 OCCUPATION House Keeper

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

# CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 4<sup>20</sup> A.M.  
 on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature) Thos B Holder  
Physician  
 (Physician or midwife)

Address Mustan Idaho

Filed Mar 2 1921. D. H. Cullen  
 Registrar

Registrar

MAR 10 1921  
 Form V. S. No. 11-C-25m-7-21-19

## STATE OF IDAHO BUREAU OF VITAL STATISTICS CERTIFICATE OF BIRTH

**S**  
87441

Registration District No. 219

File No. 87441

Primary Registration District No. 27

Registered No. 35

**N.Y. 8**—In case of mother who was a slave & her young children, taken by white men from Africa, the court has ordered that they be freed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

MAR 10 1921

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

County of *Franklin*  
City of *Mustard Ida*Registration District No. *2169*Primary Registration District No. *27*

(No. .... St.)

File No. *33086*  
Registered No. *12*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*single*  
(Write the word.)

## 6. DATE OF BIRTH.

*Feb*  
(Month)*28*  
(Day)*1921*  
(Year)

## 7. AGE

..... Yrs. .... Mos. .... ds.

IF LESS than 1 day  
how many ..... hrs. or  
..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)*none*

## 9. BIRTHPLACE

(State or Country)

*Franklin Co*

## 10. NAME OF FATHER

*McM Gibbe*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*All*

## 12. MAIDEN NAME OF MOTHER

*Maranda Taylor*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Dayton Ida*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*W M Gibb*

(Address)

*Mustard Idaho*

## 15.

Filed *Mar 3* 1921*Dr. W. M. Gibb*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Feb*  
(Month)*28*  
(Day)*1921*  
(Year)

## 17. I HEREBY CERTIFY That I attended deceased from

*Feb 28 1921* *Feb 28 1921*

that I last saw him ..... at ..... 191.....

and that death occurred on ..... at ..... M.

The CAUSE OF DEATH..... shows:

*still Birth premature Birth*  
*5 month gestation*

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) *Thos B Holder* M. D.19..... (Address) *Mustard Ida*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days In the State ..... yrs. .... mos. .... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Dayton, Ida**Apr 1* 1921

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

433-1251024-286

PLACE OF BIRTH

County of GoodingCity of WendeeRegistration District No. 24

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Baby M C Cloud

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and { Number in order of birth _____	Legitimate? <u>Yes.</u>	Date of Birth <u>Feb 25 1921</u> (Month) (Day) (Year)
--------------------------	------------------------------	--------------------------------------	-------------------------	--

FATHER		MOTHER	
FULL NAME <u>Donald F M'Cloud</u>	FULL MAIDEN NAME <u>Mary Shohoney</u>	FULL NAME <u>Mary Shohoney</u>	FULL MAIDEN NAME _____
RESIDENCE <u>Wendee</u>	RESIDENCE <u>Wendee</u>	RESIDENCE <u>Wendee</u>	RESIDENCE _____
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Illinois</u>	BIRTHPLACE <u>Missouri</u>	BIRTHPLACE <u>Missouri</u>	BIRTHPLACE _____
OCCUPATION <u>Rancher</u>	OCCUPATION <u>Housewife</u>	OCCUPATION <u>Housewife</u>	OCCUPATION _____

Number of child of this mother, including present birth <u>1</u>	Number of children of this mother now living, including present birth <u>1</u>
--	--

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was dead at 3:40 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

H. E. Lamb  
Per A. Zingg  
(Physician or midwife)

Given names added from a supplemental report.

Address

Gooding, Idaho  
Filed 3-1-1921 F. J. Canyon D.  
Registrar

2000

2000

2000

2000

254-108-025-553

PLACE OF BIRTH

County of... *Idaho* .....City of... *Keuterville* .....

No. .... St.

Registration District No. .... *105* .....Primary Registration District No. .... *2183* .....

1924 Form V. B. No. 11-C-25m-9-3-37

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

S 87490

File No. .... *4* .....

Registered No. ....

Hospital .....

FULL NAME OF CHILD... *Still born child of Alvin Bensching* .....

Sex of Child <i>Male</i>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <i>Yes</i>	Date of Birth... <i>Feb 8 1924</i> (Month) (Day) (Year)
-----------------------------	---	--	--------------------------------	--

FULL NAME <i>Alvin Henry Bensching</i>	FATHER
RESIDENCE <i>Keuterville Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY... <i>26</i> (Years)
BIRTHPLACE <i>Idaho</i>	
OCCUPATION <i>Farming</i>	

FULL MAIDEN NAME <i>Mary Entrup</i>	MOTHER
RESIDENCE <i>Same</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY... <i>19</i> (Years)
BIRTHPLACE <i>Idaho</i>	
OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth... *1st* ... Number of children of this mother now living, including present birth... *0* .....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... *Still born* ... at... *6 P* ... M. on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) ... *H. B. Blake, M.D.* .....

(Physician or midwife)

Given names added from a supplemental report.

Address... *Cottonwood Idaho* .....Filed... *Feb 9 1924* ... *H. B. Blake* .....

Registrar

Registrar

2  
BRL:U  
U.S.

## 1. PLACE OF DEATH

County of Idaho  
City of KeutervilleRegistration District No. 105Primary Registration District No. 2183

(No. .... St.)

File No. 4 33107

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Still born child of A H Bensching

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)6. DATE OF BIRTH July 8 1921  
(Month) (Day) (Year)7. AGE ..... Yrs. .... Mos. .... ds. IF LESS than 1 day  
how many ..... hrs.  
or ..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).9. BIRTHPLACE Idaho  
(State or Country)10. NAME OF FATHER Alvin Henry Bensching11. BIRTHPLACE OF FATHER Idaho  
(State or Country)12. MAIDEN NAME OF MOTHER Mary Entrop13. BIRTHPLACE OF MOTHER Idaho  
(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alvin Henry Bensching  
(Address) Keuterville Idaho15. Filed July 9 1921 H H Mlake  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8 1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 8 1921, to July 8 1921,  
that I last saw him alive on July 8 1921,  
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH\* was as follows:

still birth - instrumental delivery - mother in pre-eclampsia convulsions

..... (Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

..... (Duration) ..... yrs. .... mos. .... ds.

(Signed) H H Mlake M. D.  
2/8 1921 (Address) Cottonwood Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Keuterville Ida DATE OF BURIAL 2/9 192120. UNDERTAKER John Inager ADDRESS Keuterville Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



162.119.031.162

PLACE OF BIRTH

County of Lewis

City of Morrow

No. .... St.

Hospital .....

FULL NAME OF CHILD .....

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 60

Primary Registration District No. 2129

Form V. S. No. 270-22-17

File No. S 87560

Registered No. 5

Sex of Child <u>male</u>	Twin Triplet or other? <u>-</u> and { Number in order of birth <u>-</u>	Legitimate? <u>No</u>	Date of Birth <u>Feb. 19</u> 19 <u>17</u> (Month) (Day) (Year)
--------------------------	---	-----------------------	---

FULL NAME <u>?</u>	FATHER
RESIDENCE <u>?</u>	
COLOR <u>?</u>	AGE AT LAST BIRTHDAY <u>?</u> (Years)
BIRTHPLACE <u>?</u>	
OCCUPATION <u>?</u>	

FULL MAIDEN NAME <u>Fannie Jones</u>	MOTHER
RESIDENCE <u>Morrow, Lewis Co.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>Shattuck, Ia.</u>	
OCCUPATION <u>none</u>	

Number of child of this mother, including present birth one Number of children of this mother now living, including present birth none

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born at 11:10 P.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) John J. Farby  
Physician

Given names added from a supplemental report.

Address Craigmont, Idaho

Filed 7/24 1917  
Registrar

Registrar

Registrar

24

25

26

27

28

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

Registration District No. 68County of LewisPrimary Registration District No. 2129City of Morrow

(No. \_\_\_\_\_ St.)

File No. 33133Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME None

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

male

## 4. COLOR OR RACE

white

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

## 6. DATE OF BIRTH.

Feb. 19 1921  
(Month) (Day) (Year)

## 7. AGE

Stillborn  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs. or  
min. 2

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).None

## 9. BIRTHPLACE

(State or Country)

Lewis Co., Idaho

## 10. NAME OF FATHER

?

## 11. BIRTHPLACE OF FATHER

(State or Country)

?

## 12. MAIDEN NAME OF MOTHER

✓ Fannie Jobe

## 13. BIRTHPLACE OF MOTHER

(State or Country)

✓ Thallakee Ida

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ✓M & Jobe(Address) ✓Craigmont

## 15.

Filed

2/241921P. E. Duvall  
Local Registrar

## 16. DATE OF DEATH

Feb. 19 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw h. — alive on 191and that death occurred on the date stated above, at 11:10 P.M.

The CAUSE OF DEATH\* was as follows:

Asphyxia  
Period of utero gestation  
apparently about 8 months.  
(Duration) — Yrs. — mos. — ds.Contributory  
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) John J. Warley M. D.2-20-1921 (Address) Craigmont, Ida.

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Morrow✓ Feb. 25 1921

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc.; all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

253-214-073-846

Form V. S. No. 1-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

87612

County of MadisonCity of RexburgRegistration District No. 100

File No.

No. \_\_\_\_\_ St.

Primary Registration District No. 2178Registered No. 37

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Donna Bell

Sex of Child

FemaleTwin  
Triplet  
or other?and { Number  
in order  
of birthLegiti  
mate?yes

Date of Birth

Feb 1419 21

(Month)

(Day)

(Year)

FULL NAME

Oroville Milton Bell

FATHER

FULL MAIDEN NAME

MOTHER

Deloris Anna Huff

RESIDENCE

Rexburg Idaho

RESIDENCE

Rexburg Idaho

COLOR

White

AGE AT LAST BIRTHDAY

21

(Years)

COLOR

White

AGE AT LAST BIRTHDAY

19

(Years)

BIRTHPLACE

Rexburg Idaho

BIRTHPLACE

Teton Idaho

OCCUPATION

Blacksmith

OCCUPATION

HousewifeNumber of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was

Stillbornat 8:30 P. M.

(Born alive or stillborn)

on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

A. O. MartinPhysician

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Rexburg Idaho

Filed

3/1 21

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

FROM NO. 174-10000

04 05

Rechtsanwalt

1990

姓名: 李德仁  
 性别: 男  
 年龄: 45  
 职业: 教师  
 籍贯: 湖南长沙  
 民族: 汉族  
 宗教信仰: 无  
 婚姻状况: 已婚  
 子女情况: 一子一女  
 健康状况: 良好  
 兴趣爱好: 读书、运动  
 特长: 写作、演讲  
 座右铭: 天道酬勤  
 自我评价: 为人正直, 诚实守信, 热爱工作, 乐于助人。

(afforded) to serve at your pleasure.

**NAME**

JUL  
 2014  
 2014

9

2000

COLORED

**Color**

**25-587510**

SECRET

14

THE UNIVERSITY OF CHICAGO

CHRISTIANITY IN A TROPICAL PHYSICIAN'S MIND.

**Abstract**

**Abstract**

\_\_\_\_\_

THE NEW YORK HERALD TRIBUNE  
OFFICE: 100 NASSAU ST. N. Y. C.  
PUBLISHED DAILY  
EXCEPT SUNDAY AND HOLIDAYS  
TERMS: \$5 PER ANNUM IN ADVANCE  
SINGLE COPIES 10 CENTS  
ADVERTISING: \$10 PER LINE PER WEEK  
ESTABLISHED 1857

WRITE PLAINLY, WITH UNFADING INK—GIVE AS MUCH INFORMATION AS POSSIBLE. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH

1. PLACE OF DEATH

County of *Madison*  
City of *Repuburg*  
If death occurs away from usual residence, give facts called for under special information.

Registration District No. *100*  
Primary Registration District No. *2178*  
(No. .... St.)

Bureau of Vital Statistics  
File No. *33144*  
Registered No. *14*  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Donna Bill*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Fe* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*  
(Write the word.)

6. DATE OF BIRTH *Feb. 14 1921*  
(Month) (Day) (Year)

7. AGE ..... Yrs. .... Mos. .... ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work *Infant*  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE  
(State or Country) *Madison Co*

10. NAME OF FATHER *Arville M. Bell*

11. BIRTHPLACE OF FATHER  
(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER *Deloris A. Huff*

13. BIRTHPLACE OF MOTHER  
(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Arville M. Bell*  
(Address) *Repuburg, Idaho*

15. Filed *2/15* 19*21*  
Local Registrar. *G. G. West*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb 14 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb. 14 1921* to *Feb. 14 1921*  
that I last saw him ..... alive on ..... 191.....  
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:  
*Still Born*  
(Duration) ..... Yrs. .... mos. .... ds.

Contributory (Secondary) .....  
(Duration) ..... Yrs. .... mos. .... ds.  
(Signed) *Dr. M. D. Rexturing*  
*2-15-1921* (Address) *Repuburg, Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days, State ..... yrs. .... mos. .... days  
Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL *Idaho City, Idaho* DATE OF BURIAL *2-16-1921*  
20. UNDERTAKER *Repuburg* ADDRESS *Repuburg*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoncum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



559.107-033-499

PLACE OF BIRTH

STATE OF IDAHO <sup>1921</sup> Form V. S. No. 11-C-25m-1-1-18  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

County of MadisonCity of RisingRegistration District No. 100File No. **S 87656**

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2178Registered No. 12

Hospital \_\_\_\_\_

## FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of Birth <u>1-7-1921</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	---

FULL NAME Olaf P. Neilson FATHERRESIDENCE Weston IdaCOLOR White AGE AT LAST BIRTHDAY 43  
(Years)BIRTHPLACE UtahOCCUPATION FarmerFULL MAIDEN NAME Eva Linkwater MOTHERRESIDENCE Weston IdaCOLOR White AGE AT LAST BIRTHDAY 42  
(Years)BIRTHPLACE New ZealandOCCUPATION HousewifeNumber of child of this mother, including present birth 10 Number of children of this mother now living, including present birth 9

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 P.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Louis F. Rich  
(Physician or midwife)

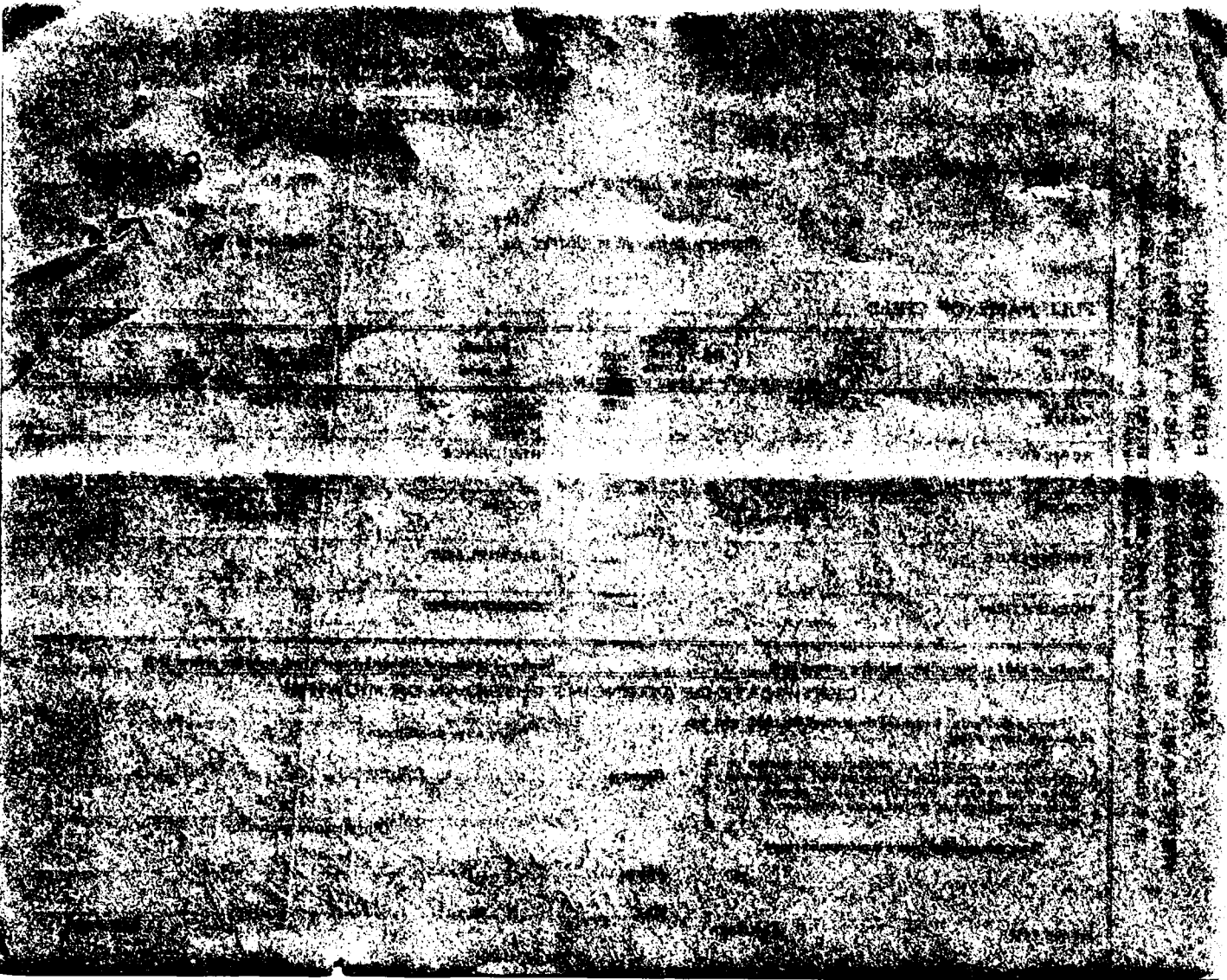
Given names added from a supplemental report.

Address Rising IdahoFiled 1/11 1921 G. H. Spe

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

# CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Madison  
City of Rexburg

Registration District No. 100  
Primary Registration District No. 2178  
(No. \_\_\_\_\_ St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 33154  
Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME Baby Nielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

### PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child  
(Write the word.)

6. DATE OF BIRTH Jan. 7th 1921  
(Month) (Day) (Year)

7. AGE Still Born  
IF LESS than 1 day how many \_\_\_\_ hrs. \_\_\_\_ min. \_\_\_\_ sec.  
----- Yrs. ----- Mos. ----- ds.

8. OCCUPATION  
(a) Trade, profession or particular kind of work. \_\_\_\_\_  
(b) General nature of industry, business or establishment in which employed (or employer). \_\_\_\_\_

9. BIRTHPLACE Idaho  
(State or Country)

10. NAME OF FATHER John P. Nielsen

11. BIRTHPLACE OF FATHER Utah  
(State or Country)

12. MAIDEN NAME OF MOTHER Eva D. Drinkwater

13. BIRTHPLACE OF MOTHER New Zealand  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) John P. Nielsen  
(Address) Weston, Ida.

15. Filed 1/8 1921  
Local Registrar G. E. Espe

### MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 7th 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7th 1921 to Jan. 7th 1921  
that I last saw him Jan 7 1921  
and that death occurred on the date stated above, at \_\_\_\_\_ M.  
The CAUSE OF DEATH\* was as follows:

Stillborn

----- (Duration) ----- Yrs. ----- mos. ----- ds.  
Contributory (Secondary) \_\_\_\_\_  
(Duration) ----- yrs. ----- mos. ----- ds.  
(Signed) L. J. Rich M. D.  
1/10 1921 (Address) Rexburg Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL Weston, Ida. DATE OF BURIAL 1/12 1921  
20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

713-124,035-366

MAR 10 1921

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. E. No. 11-C-22m-22-17

County Nezperce

City of Lewiston

No. 1504 Main St.

Hospital White

Registration District No. 96

Primary Registration District No. 1009

S 87706  
File No. 623

FULL NAME OF CHILD

Patterson

Sex of Child <u>Male</u>	Twins or other? <u>X</u>	Number in order of birth <u>X</u>	Legitimate? <u>Yes</u>	Date of Birth <u>1 24 1921</u> (Month) (Day) (Year)
--------------------------	--------------------------	-----------------------------------	------------------------	--

FULL NAME <u>E. J. Patterson</u>	FATHER
RESIDENCE <u>Almota Wn</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>West Virginia</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Worris Cook</u>	MOTHER
RESIDENCE <u>Almota Wn</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>W. W.</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was at 2:30 A.M. on the date above stated. (~~Delivered or stillborn~~)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Edgar L. White  
Physician or midwife

Given names added from a supplemental report.

Address Lewiston  
Filed Feb 3 21 Idaho E. Bruce Registrar

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

NAME	LAST, FIRST, MIDDLE	DATE OF BIRTH	SEX	RACE	EDUCATION	EMPLOYMENT	RESIDENCE	RELIGION	POLITICAL AFFILIATION	ACTIVITY
[Illegible]	[Illegible]	[Illegible]	[Illegible]	[Illegible]	[Illegible]	[Illegible]	[Illegible]	[Illegible]	[Illegible]	[Illegible]

REMARKS: [Illegible]

DATE OF REPORT: [Illegible]

REPORTED BY: [Illegible]

APPROVED BY: [Illegible]

## CERTIFICATE OF DEATH

MAR 10 1921 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 33172  
Registered No. 594

## 1. PLACE OF DEATH

County of Boise  
City of LeicesterRegistration District No. 96  
Primary Registration District No. 1009  
(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Everett Patterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDMale White Single  
(Write the word.)

## 6. DATE OF BIRTH

1 24 1921  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Boise Idaho

## 10. NAME OF FATHER

Everett Patterson

## 11. BIRTHPLACE OF FATHER

(State or Country)

N. Virginia

## 12. MAIDEN NAME OF MOTHER

W. Cook

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Ida.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Boy Paulley  
Leicester Ida.

## 15.

Filed Feb 8 1921 Sam E. Bruce  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

1 24 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Edgar L. White M. D.19 (Address) Leicester Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Leicester Ida. Feb 8

## 20. UNDERTAKER

## ADDRESS

Passar Undertaking Co. Leicester

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

819-209-001-613

PLACE OF BIRTH

County of AdaCity of Boise~~No near Fair Grounds~~

Hospital \_\_\_\_\_

FULL NAME OF CHILD

RECEIVED

APR 7 1921

BUREAU OF VITAL  
STATISTICS

Registration District No. \_\_\_\_\_

Primary Registration District No. 2021Baby HarrahSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

87993

S

~~32487~~File No. 39Registered No. 39

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>3-9-1921</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	----------------------------	--

FULL NAME <u>B. F. Harrah</u>	FATHER
RESIDENCE <u>R.D. #2, Boise, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Oregon</u>	
OCCUPATION <u>Horticulturist</u>	

FULL MAIDEN NAME <u>Alice F. Wallick</u>	MOTHER
RESIDENCE <u>R.D. #2, Boise, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Kansas</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn, at 8:15 a. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature) J. M. Taylor  
(Physician or midwife)

Address Boise, IdahoFiled Mar 14 19 21 R. H. Prater

Registrar

Registrar

RECEIVED  
JUN 10 1964  
BUREAU OF  
STATISTICS  
Washington 1

STATE OF OHIO  
OFFICE OF THE  
SHERIFF

Name		Date of Birth		Sex		Race		Height		Weight		Eyes		Hair		Complexion		Scars or Marks		Fingerprints		Signature		Date	
JAMES EARL RAY		01-01-1924		M		W		5-11		175		Blue		Brown		Fair									
Place of Birth		Date of Birth		Sex		Race		Height		Weight		Eyes		Hair		Complexion		Scars or Marks		Fingerprints		Signature		Date	
MOBILE, ALABAMA		01-01-1924		M		W		5-11		175		Blue		Brown		Fair									
Residence		Date of Birth		Sex		Race		Height		Weight		Eyes		Hair		Complexion		Scars or Marks		Fingerprints		Signature		Date	
1000 1/2 N. 1st St., Memphis, Tenn.		01-01-1924		M		W		5-11		175		Blue		Brown		Fair									
Occupation		Date of Birth		Sex		Race		Height		Weight		Eyes		Hair		Complexion		Scars or Marks		Fingerprints		Signature		Date	
None		01-01-1924		M		W		5-11		175		Blue		Brown		Fair									
Distance		Date of Birth		Sex		Race		Height		Weight		Eyes		Hair		Complexion		Scars or Marks		Fingerprints		Signature		Date	
1000 1/2 N. 1st St., Memphis, Tenn.		01-01-1924		M		W		5-11		175		Blue		Brown		Fair									
Declaration		Date of Birth		Sex		Race		Height		Weight		Eyes		Hair		Complexion		Scars or Marks		Fingerprints		Signature		Date	
I declare that I am the person named above and that I am the person who has been arrested and who is being held in custody.		01-01-1924		M		W		5-11		175		Blue		Brown		Fair									

CERTIFICATE OF AFTERSHOCK MEDICIAN OR NURSE

I hereby certify that I attended the birth of the child above named on the date and at the place indicated below.

Name of Child: JAMES EARL RAY

Date of Birth: 01-01-1924

Place of Birth: MOBILE, ALABAMA

Signature: [Signature]

Date: [Date]

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **33278**  
Registered No. **23**

## 1. PLACE OF DEATH

Registration District No. **8**  
County of **Ada** RECEIVED  
City of **Baise** APR 7 1921  
b and Orchard ave St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF HEALTH

2. FULL NAME

**Mary Jane Harrah**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**  
(Write the word.)

## 6. DATE OF BIRTH

**Mar 9<sup>th</sup> 1921**  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many hrs. or min.?  
Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

**none**

## 9. BIRTHPLACE

(State or Country)

**Ada County, Idaho**

## 10. NAME OF FATHER

**B. F. Harrah**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Oregon**

## 12. MAIDEN NAME OF MOTHER

**Fern Wallick**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Kansas**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **B. F. Harrah**  
(Address)

15. **Mar 9 - 1921**  
Filed

**P. H. Crace**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Mar 9<sup>th</sup> 1921**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Mar 9<sup>th</sup> 1921** to **Mar 9<sup>th</sup> 1921**  
that I last saw h. f. alive on **Mar 9<sup>th</sup> 1921**  
and that death occurred on the date stated above, at **8:15 AM**

The CAUSE OF DEATH\* was as follows:

**Still born - had been dead some days - could not determine cause**

(Duration) Yrs. mos. ds.  
**gestation 39 weeks**  
(Contributory (Secondary))  
(Duration) yrs. mos. ds.

(Signed) **J. M. Taylor** M. D.  
**Mar 9 1921** (Address) **J. M. Taylor, Ada**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Harris Hill Cem** DATE OF BURIAL **3/9 1921**

20. UNDERTAKER **Schreiber & Sidenfaden** ADDRESS **Baise**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1897  
22

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

73126001-967

PLACE OF BIRTH

STATE OF IOWA  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S 88003

County of Ada

City of Boonville

RECEIVED

APR 25 1921

BUREAU OF VITAL STATISTICS

No. \_\_\_\_\_

Registration District No. 18

File No. 32407

Hospital \_\_\_\_\_

Primary Registration District No. 2004

Registered No. 49

FULL NAME OF CHILD

Infant Plain

Sex of Child

M

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and

Number  
in order  
of birth

Legitimate?

yes

Date of Birth

May 26

1921

FULL NAME

Homer E Plain

FATHER

FULL MAIDEN NAME

Eva Rogers

MOTHER

RESIDENCE

Eagle R 1

RESIDENCE

Eagle R 1

COLOR

W

AGE AT LAST BIRTHDAY

35  
(Years)

COLOR

W

AGE AT LAST BIRTHDAY

35  
(Years)

BIRTHPLACE

Kansas

BIRTHPLACE

Mo.

OCCUPATION

farmer

OCCUPATION

Housewife

Number of children of this mother, including present birth 2

Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

(Deadborn or stillborn)

at 49 M.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

D. H. Parker

(Physician or midwife)

Given names added from a supplemental report.

19

Address

303 Mc Carthy

Filed

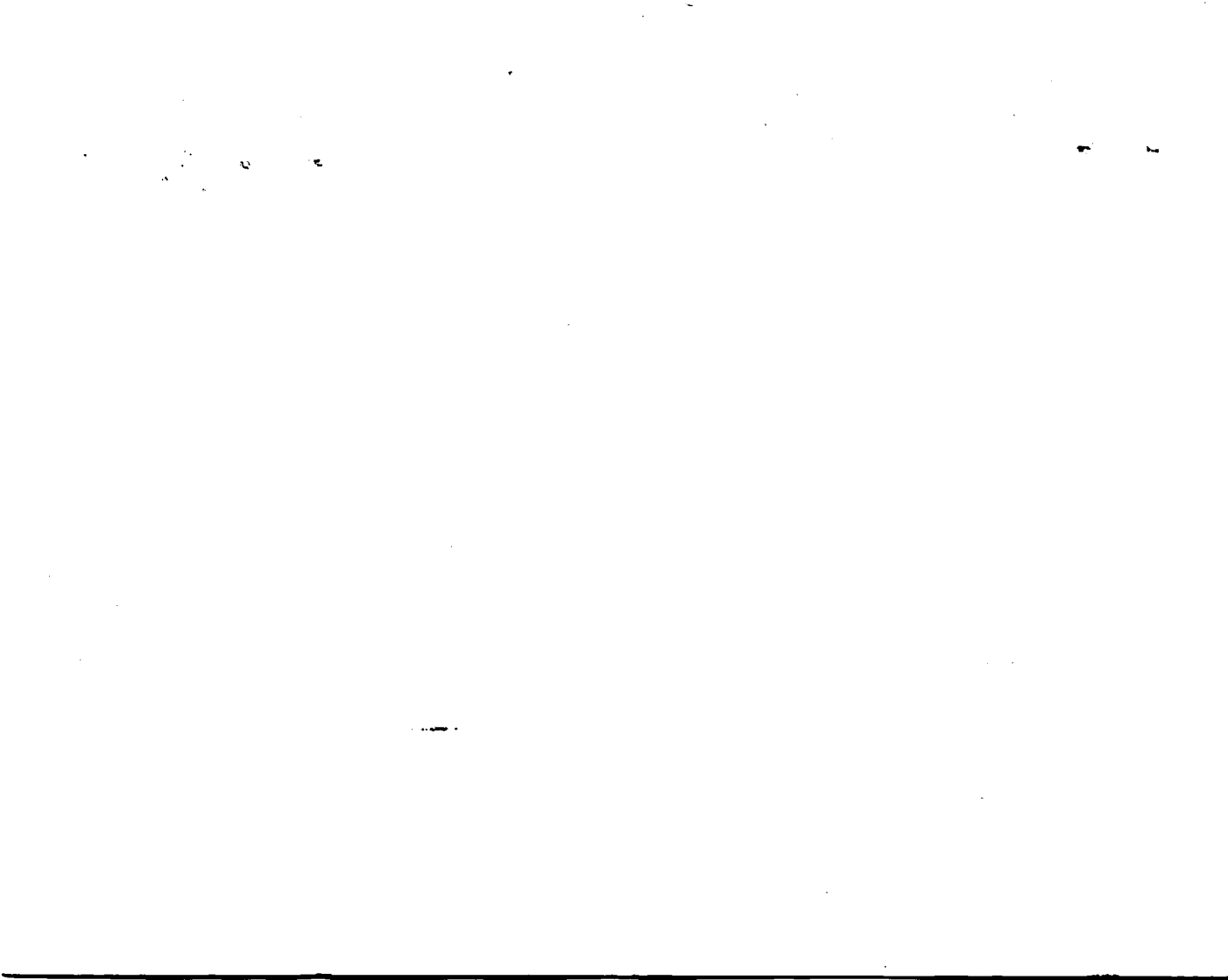
Mar 29

19

21

Registrar

Registrar



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Ada*

City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
Registration District No. *9*

Primary Registration District No.

BUREAU OF VITAL  
STATISTICSFile No. *33669*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

*Infant Plain*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*M*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Single*

## 6. DATE OF BIRTH

*Mar 26 1921*

## 7. AGE

*Yrs. Mos. ds.*IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

(State or Country)

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

(State or Country)

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

*Mar 26 1921**1921**Frederic K. Levan*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Mar 26 1921*

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*still born*

## 16. DATE OF DEATH

*Mar 26 1921*

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*still born*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

272

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

814-2041007-692

PLACE OF BIRTH

RECEIVED

Form V. S. No. 11-C-25m-7-21-19

APR 11 1924

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

S

88024

County of Bannock

CERTIFICATE OF BIRTH

City of Swan Lake

BUREAU OF VITAL STATISTICS

Registration District No. 83

File No. 82488

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2160

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD Not named

Sex of Child <u>girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>Jan-4-1921</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	----------------------------	---

FATHER  
FULL NAME Rich Hadley  
RESIDENCE Swan Lake, Ida  
COLOR white AGE AT LAST BIRTHDAY 36  
(Years)  
BIRTHPLACE Swan Lake  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Sillie Fisher  
RESIDENCE Swan Lake, Ida  
COLOR white AGE AT LAST BIRTHDAY 34  
(Years)  
BIRTHPLACE Oxford, Ida  
OCCUPATION Wife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

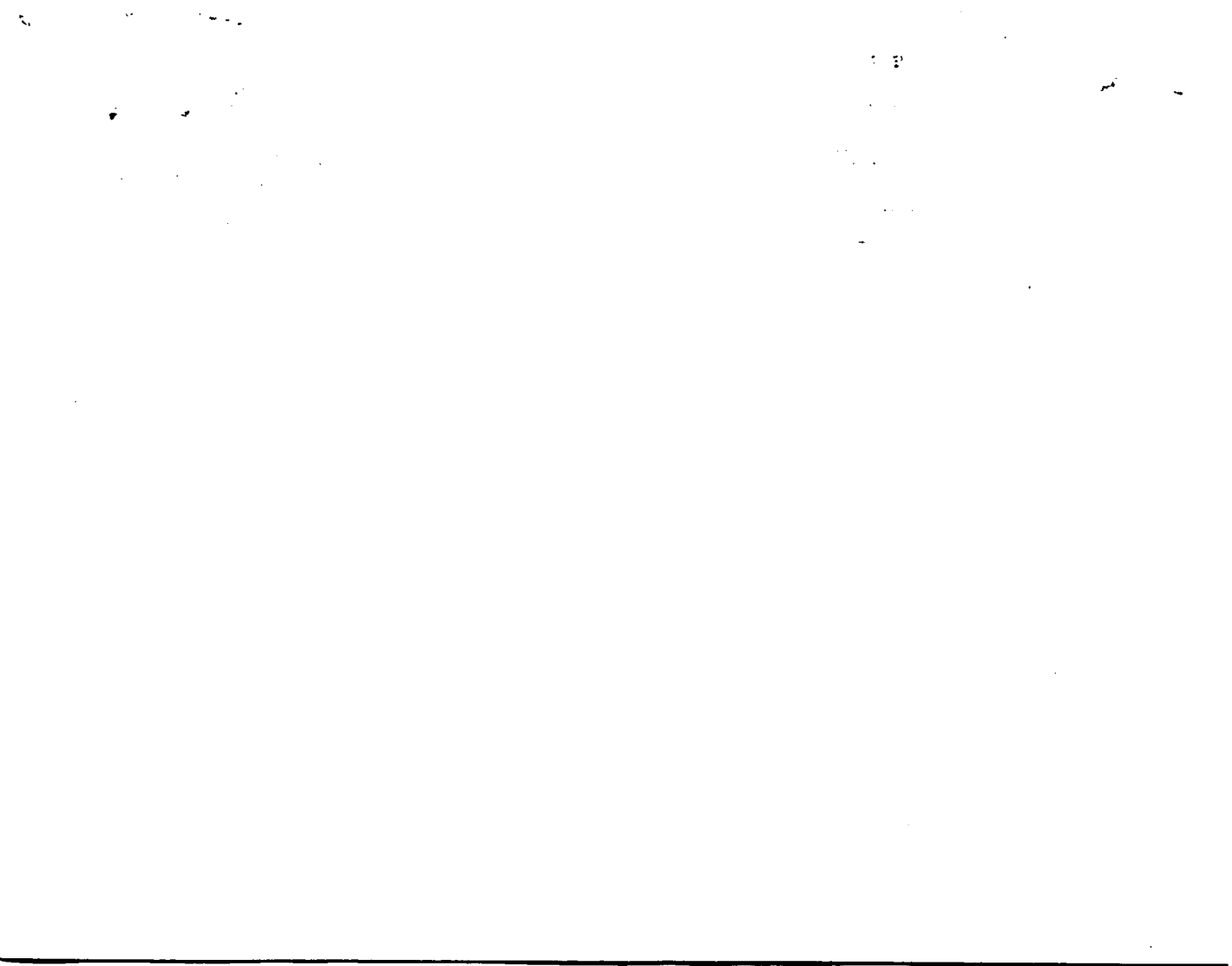
I hereby certify that I attended the birth of this child, who was Stillborn, at 3.00 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address [Signature]  
Filed Jan 10, 1924  
Registrar [Signature]



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 33290

1. PLACE OF DEATH  
County of Bannock  
City of Swan Lake  
Registration District No. 83  
Primary Registration District No. 3160  
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word.)

6. DATE OF BIRTH  
Jan (Month) 4 (Day) 1921 (Year)

7. AGE Stillborn IF LESS than 1 day how many hrs. or min.?  
Yrs. Mos. ds.

8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Swan Lake, Ida.  
(State or Country)

10. NAME OF FATHER Rich Hadley

11. BIRTHPLACE OF FATHER Swan Lake  
(State or Country)

12. MAIDEN NAME OF MOTHER Lillie Fisher

13. BIRTHPLACE OF MOTHER Oxford, Idaho.  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Rich Hadley  
(Address) Swan Lake, Ida.

15. Filed Jan 12 1921 H. H. Harrison  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH  
Jan (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1921, to Jan 4 1921, that I last saw h. alive on Jan 4 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:  
Eight months gestation

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Harrison M. D.

1-5-1921 (Address) Shawnee, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Swan Lake, Ida. DATE OF BURIAL 1-5-1921

20. UNDERTAKER None ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

15793

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

219-222-004-855  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11—20m-7-24-19

S 88095

County of Bear Lake

City of St. Charles

Registration District No. 2132

File No. 32009

No. \_\_\_\_\_ St.

Primary Registration District No. 53

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Still Born.

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of Birth <u>Feb 22</u> 19 <u>21</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	--

FATHER  
FULL NAME John Barker  
RESIDENCE St. Charles, Idaho  
COLOR White AGE AT LAST BIRTHDAY 48 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Cather Eleanor Henderson  
RESIDENCE St. Charles, Idaho  
COLOR White AGE AT LAST BIRTHDAY 40 (Years)  
BIRTHPLACE Randolph, Utah  
OCCUPATION Housewife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, Still born alive at 12<sup>10</sup> A. M.  
on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

D. J. Sutton  
MD

(Physician or midwife)

Given names added from a supplemental report.

Address

Paris

Filed

3/10/21

19

Registrar.

Registrar.

THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES  
DEPARTMENT OF CHEMISTRY

51

100

944-106-005-718

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-0-22a-2-17

S 88107

County of *Benedict*

APR 11 1921

City of *St Joe*

BUREAU OF VITAL STATISTICS

Registration District No. *32*

File No. *2071*

No. *2049*

Primary Registration District No. *2049*

Registered No. *27*

Hospital

FULL NAME OF CHILD

*Baby Rudy*

Sex of Child <i>Male</i>	Twin Triplet or other? <i>and</i> (To be answered only in event of plural births)	Legitimate? <i>Yes</i>	Date of Birth <i>Mar 6 1921</i> (Month) (Day) (Year)
--------------------------	---	------------------------	---

FULL NAME <i>Fred Rudy</i>	FATHER
RESIDENCE <i>St. Joe, Ida.</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>28</i> (Years)
BIRTHPLACE <i>Pennsylvania</i>	
OCCUPATION <i>Teamster</i>	

FULL MAIDEN NAME <i>Violet Gay</i>	MOTHER
RESIDENCE <i>St. Joe, Ida.</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>21</i> (Years)
BIRTHPLACE <i>England</i>	
OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth... *1*... Number of children of this mother now living, including present birth... *1*...

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was *stillborn* at *12:30 P.M.* on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *C. A. Robins*

Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address *St. Marie, Ida.*

Filed *Mar 7 1921*

Registrar

Registrar

1. ~~SECRET~~

2. ~~SECRET~~

3. ~~SECRET~~

4. ~~SECRET~~

5. ~~SECRET~~

6. ~~SECRET~~

7. ~~SECRET~~

8. ~~SECRET~~

9. ~~SECRET~~

10. ~~SECRET~~

11. ~~SECRET~~

12. ~~SECRET~~

13. ~~SECRET~~

14. ~~SECRET~~

15. ~~SECRET~~

16. ~~SECRET~~

17. ~~SECRET~~



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 33319  
Registered No. 8

1. PLACE OF DEATH  
County of Benzonia Registration District No. 32  
City of St. Joe Primary Registration District No. 2049  
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Rudy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
OWER OR DIVORCED Single

6. DATE OF BIRTH March 6 1921  
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day  
how many hrs. or min.?

8. OCCUPATION Infant  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE St Joe, Idaho  
(State or Country)

10. NAME OF FATHER Fred Rudy

11. BIRTHPLACE OF FATHER Pennsylvania  
(State or Country)

12. MAIDEN NAME OF MOTHER Violet Gay

13. BIRTHPLACE OF MOTHER England  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) C. A. Reber  
(Address) St. Maries

15. Filed March 7 1921 A. E. Humph  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 6 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1921 to March 6 1921  
that I last saw h. alive on 19  
and that death occurred on the date stated above, at M.  
The CAUSE OF DEATH\* was as follows:  
Stillbirth

(Period of uterine gestation) 9 mo.  
(Duration) Yrs. mos. ds.  
Contributory (Secondary) Gonorrhea, due to transverse presentation  
(Duration) yrs. mos. ds.  
(Signed) C. A. Reber M. D.  
3/6 1921 (Address) St. Maries, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days  
Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL St. Joe DATE OF BURIAL 3/6 1921

20. UNDERTAKER By Friends ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1897

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

133-215-005-255

PLACE OF BIRTH

RECEIVED

Form V. S. No. 11-C-25m-7-21-19

APR 11 1921

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

S 88108

County of Bennett

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

City of St. Maries

Registration District No. 32

File No. 38312

No. \_\_\_\_\_ St.

Primary Registration District No. 2049

Registered No. 28

Hospital \_\_\_\_\_

FULL NAME OF CHILD Louis S. Allison

Sex of Child <u>7</u>	Twin Triplet or other? <u>✓</u> and {	Number in order of birth (To be answered only in event of plural births) <u>1</u>	Legiti mate? <u>yes</u>	Date of Birth <u>3</u> <u>15</u> <u>1921</u> (Month) (Day) (Year)
-----------------------	---	--	----------------------------	--

FULL NAME <u>Alon S. Allison</u>	FATHER
RESIDENCE <u>Elk River Ida</u>	
COLOR <u>w</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Mich</u>	
OCCUPATION <u>Bookman</u>	

FULL MAIDEN NAME <u>Marie Benoit</u>	MOTHER
RESIDENCE <u>Elk River</u>	
COLOR <u>w</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Ida</u>	
OCCUPATION <u>House wife</u>	

Number of child of this mother, including present birth \_\_\_\_\_ Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Chas Benoit, at 8 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

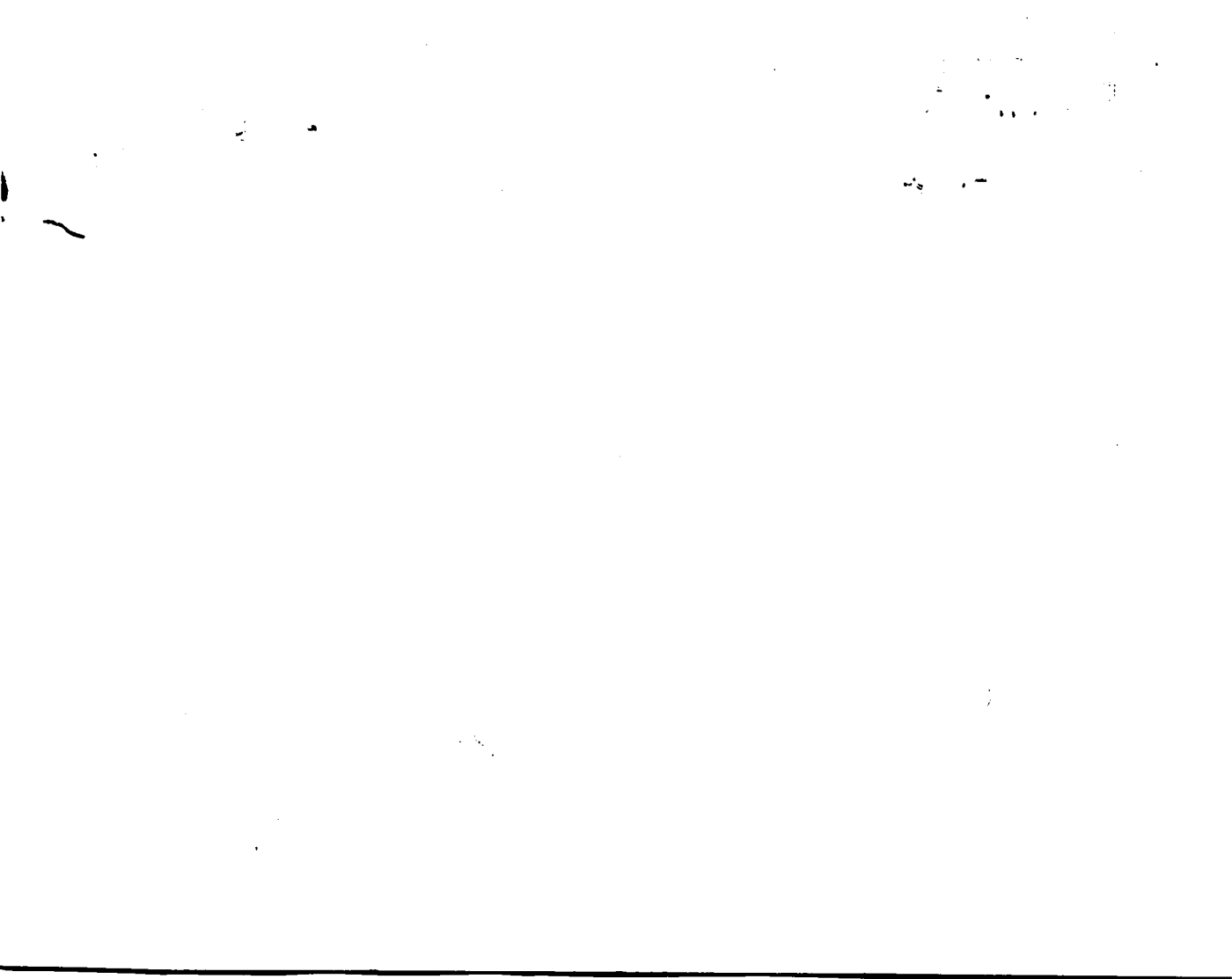
(Signature) Oct Oct  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address St. Maries Ida

Filed March 15 1921 H E Hunt  
Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH **APR 11 1921**  
County of **Bannock** Registration District No. **32**  
City of **St. Maries** Secondary Registration District No. **2049**  
(No. .... St.)

File No. **33316**  
Registered No. **17**

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Francis L. Allison**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word.)

16. DATE OF DEATH  
**3** **15** **21**  
(Month) (Day) (Year)

6. DATE OF BIRTH  
**3** **15** **1921**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **3-15** **1921** to **March** **19** that I last saw him **alive** on **19** and that death occurred on the date stated above, at **19** M. The CAUSE OF DEATH\* was as follows:

7. AGE **Still Born** IF LESS than 1 day how many **hrs.** or **mins.?**  
Yrs. Mos. ds.

**Still Born**  
**8 months**  
(Duration) Yrs. mos. ds.  
Contributory (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) **W. R. Att** M. D.  
**3/15** **1921** (Address) **St. Maries Idaho**

8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

9. BIRTHPLACE **Idaho**  
(State or Country)

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

10. NAME OF FATHER **Oscar L. Allison**

At place of death yrs. mos. days. In the State yrs. mos. days

11. BIRTHPLACE OF FATHER **Michigan**  
(State or Country)

Where was disease contracted if not at place of death?

12. MAIDEN NAME OF MOTHER **Maria Benscoter**

Former or usual residence

13. BIRTHPLACE OF MOTHER **Idaho**  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **Oscar L. Allison**  
(Address) **Elk River Ida.**

19. PLACE OF BURIAL OR REMOVAL **Woodlawn** DATE OF BURIAL **2-15** **1921**

15. Filed **March 15** **1921** **Heathurst**  
Local Registrar

20. UNDERTAKER **Mitchell & Menzies** ADDRESS **St. Maries**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1894  
20

386-107-006-653

## PLACE OF BIRTH

County of BinghamCity of Thomas PietRegistration District No. 121No.        St.       Primary Registration District No. 2194Hospital       FULL NAME OF CHILD Norm ThomasSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-G-22a-4-17

S 88121

File No. 88121Registered No. 66

Sex of Child <u>Male</u>	Twin <u>Yes</u> and { Number in order of birth <u>1st</u> }	Legitimate <u>Yes</u>	Date of Birth <u>Feb 7 1912</u> (Month) (Day) (Year)
--------------------------	---	-----------------------	---

FULL NAME <u>William Henry Thomas</u>	FATHER
---------------------------------------	--------

RESIDENCE <u>Blackfoot Ida Route 2</u>	
--	--

COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>47</u> (Years)
--------------------	---

BIRTHPLACE <u>Cal.</u>	
------------------------	--

OCCUPATION <u>Farmer</u>	
--------------------------	--

FULL MAIDEN NAME <u>Martha Filsted</u>	MOTHER
--	--------

RESIDENCE <u>do</u>	
---------------------	--

COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
--------------------	---

BIRTHPLACE <u>Utah</u>	
------------------------	--

OCCUPATION <u>House wife</u>	
------------------------------	--

Number of child of this mother, including present birth <u>5</u>	Number of children of this mother now living, including present birth <u>4</u>
--	--

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was        at 4:30 P.M. on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. E. Patrice M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address Blackfoot IdaFiled 3-10 1921 Mrs. Valia E. Patrice

Registrar

Registrar





## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **33324**  
Registered No. **20**

## 1. PLACE OF DEATH

County of **Bingham**  
City of **Thomas Pict.**

Registration District No. **121**  
Primary Registration District No. **2194**  
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**William Thomas**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

**Male**

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

**Single**  
(Write the word.)

## 6. DATE OF BIRTH

**Feb 7 1921**  
(Month) (Day) (Year)

## 7. AGE

**Stillborn**  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

**None**

## 9. BIRTHPLACE

(State or Country)

**Thomas Pict., Bingham Co Idaho**

## 10. NAME OF FATHER

**Wm Henry Thomas**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Cal.**

## 12. MAIDEN NAME OF MOTHER

**Martha T. T. T.**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Utah**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**Peter J. Felsch**  
(Address) **Bluffton Rd Route 2**

## 15.

Filled

**Feb 8 1921**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Feb 7 1921**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Feb 7 1921** to **Feb 7 1921** that I last saw him alive on **Feb 7 1921** and that death occurred on the date stated above, at **4:15 P.M.**

The CAUSE OF DEATH\* was as follows:

**Stillborn - Premature**  
**6 1/2 mo in utero**

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

**M. E. Patrick** M. D.

**7/8 1921** (Address) **Bluffton Rd**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Thomas - Bluffton Rd** **Feb 9 1921**

## 20. UNDERTAKER

## ADDRESS

**Peter J. Felsch**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name or origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

127

386-107.006-653

## PLACE OF BIRTH

County of BinghamCity of Thomas River

No. .... St.

Hospital .....

FULL NAME OF CHILD David ThomasSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. M-G-21-2-17

S 88122

Registration District No. 121File No. 38580Primary Registration District No. 2194Registered No. 67

Sex of Child <u>Male</u>	Twin <u>Yes</u> and (Number in order of birth <u>2nd</u> ) (To be answered only in event of plural births)	Legitimate <u>Yes</u>	Date of Birth <u>Feb 7 1921</u> (Month) (Day) (Year)
--------------------------	---	-----------------------	---

FULL NAME <u>Mr. Harry Thomas</u>	FATHER
-----------------------------------	--------

FULL MAIDEN NAME <u>Martha Helsted</u>	MOTHER
--	--------

RESIDENCE <u>Bluefoot P.O. Route 2</u>	
--	--

RESIDENCE <u>Do</u>	
---------------------	--

COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>47</u> (Years)
--------------------	---

COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
--------------------	---

BIRTHPLACE <u>Cal</u>	
-----------------------	--

BIRTHPLACE <u>Utah</u>	
------------------------	--

OCCUPATION <u>Farmer</u>	
--------------------------	--

OCCUPATION <u>Housewife</u>	
-----------------------------	--

Number of child of this mother, including present birth <u>6</u>	Number of children of this mother now living, including present birth <u>4</u>
--	--

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Shelton, at 431 P on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. E. Patrice M.D.

Given names added from a supplemental report.

(Physician or midwife)

.....19.....

Address Bluefoot Idaho

.....1921.....

Filed 3-10 1921 Mrs. Helen E. Patrice

Registrar

Registrar

It was not always the case that the "Bible" was the only source of information for the "Bible" and the "Bible" was not always the only source of information for the "Bible".

10-10-68 - U.S. Air Force

.....

4444

YEAH YEAH YEAH  
YEAH YEAH YEAH

2049 45-2

Figure 1. The effect of the concentration of the *Agaricus bisporus* spores on the growth of *Agaricus bisporus* on the substrate.

WDS

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **33325**  
Registered No. **51**

## 1. PLACE OF DEATH

County of *Bingham*  
City of *Thomas Beck*

Registration District No. *221*  
Primary Registration District No. *2194*  
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*David Thomas*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Single*  
(Write the word.)

## 6. DATE OF BIRTH

*Feb 7 1921*  
(Month) (Day) (Year)

## 7. AGE

*Stillborn*  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

*None*

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

*Thomas Beck  
Bingham Co Ida*

## 10. NAME OF FATHER

*Wm Henry Thomas*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Cal*

## 12. MAIDEN NAME OF MOTHER

*Martha Helsted*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Utah*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Peter J. Helsted*

(Address)

*Blackfoot Bingham Co Ida Dist 2*

## 15.

Filled

*Feb 8 1921*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Feb 7 1921*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*Feb 7 1921* to *Feb 7 1921*  
that I last saw him alive on *Feb 7 1921*  
and that death occurred on the date stated above, at *4:30 PM*.

The CAUSE OF DEATH\* was as follows:

*Stillborn Premature  
6 1/2 mo*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

*W. E. Putrie M. D.*

*2/8 1921* (Address) *Blackfoot Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Thomas - Bingham Co Ida* *Feb 9 1921*

## 20. UNDERTAKER

## ADDRESS

*Peter J. Helsted*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1899

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

653-103-007-653

PLACE OF BIRTH

County of Blaine

City of Carey

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

RECEIVED

APR 11 1921

BUREAU OF VITAL STATISTICS

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S 88175

32639

Primary Registration District No. 2075

Registered No. 15

Sex of Child <u>male</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legiti mate? <u>yes</u>	Date of Birth <u>3</u> <u>3</u> <u>21</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

FATHER  
FULL NAME Austin L. Melch  
RESIDENCE Carey Idaho  
COLOR white AGE AT LAST BIRTHDAY 41  
(Years)  
BIRTHPLACE Iowa  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Marnie Melch  
RESIDENCE Carey Idaho  
COLOR white AGE AT LAST BIRTHDAY 33  
(Years)  
BIRTHPLACE Missouri  
OCCUPATION Housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Houston E. Snyder  
Physician  
(Physician or midwife)

Given names added from a supplemental report.  
\_\_\_\_\_ 19 \_\_\_\_\_

Address Carey Idaho  
Filed 3-30 19 21 Robert H. Wright  
Registrar

Registrar

Registrar

DO NOT WRITE IN THESE SPACES  
 This report is to be used for the purpose of recording the birth of a child and for the purpose of recording the death of a child.

PLACE OF BIRTH

CERTIFICATE OF BIRTH  
 OF ILLINOIS  
 STATISTICAL BUREAU

County of \_\_\_\_\_  
 City of \_\_\_\_\_

Registration District No. \_\_\_\_\_  
 Birth No. \_\_\_\_\_  
 Primary Registration District No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Sex of  
 (Child)

Twins  
 or other  
 children

Number  
 and  
 of birth

Age of  
 mother

Place of  
 birth

FATHER

Full  
 name

Full  
 maiden  
 name

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST  
 BIRTHDAY

COLOR

AGE AT LAST  
 BIRTHDAY

BIRTHPLACE

BIRTHPLACE

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 57

County of

APR 11 1921

Primary Registration District No. 2075

City of

BUREAU OF VITAL  
STATISTICS

St.)

File No. 33337

Registered No. 6

If death occurs away from  
usual residence, give facts  
called for under special  
information.

2. FULL NAME

Baby. Welch

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.Baby.  
(Write the word.)

6. DATE OF BIRTH.

3

3

1921

(Month)

(Day)

(Year)

7. AGE

Still born

IF LESS than 1 day  
how many.....hrs. or  
.....min.?

8. OCCUPATION

(a) Trade, profession or  
particular kind of work...  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which employ-  
ed (or employer).

Baby.

9. BIRTHPLACE

(State or Country)

Barey

10. NAME OF  
FATHER

Austin J. Welch

11. BIRTHPLACE  
OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME  
OF MOTHER

Mamie Horgan

13. BIRTHPLACE  
OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Austin J. Welch

15.

Filed

3-1

1921

R.H. Wright

Local Registrar

16. DATE OF DEATH

3

3

1921

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from  
Mar 3 1921 to Mar 3 1921.

that I last saw h. — alive on — 191.

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) — Yrs. — mos. — ds.

Contributory  
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Austin J. Welch M. D.

19 (Address) Barey Idaho

\*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1)  
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted  
if not at place of death?

Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Barey, Ida

3-4 1921

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

1692

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

363-101-009-393

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 88202

County of Bonner

City of Shoshone

Registration District No. 70

File No. 32666

No. 7134 Boyer St.

Primary Registration District No. 2155

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Still born

Sex of Child <u>male</u>	Twin Triplet or other? <u>—</u> (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legiti mate? <u>yes</u>	Date of Birth <u>Jan 1</u> (Month) (Day) (Year) <u>1921</u>
-----------------------------	--	-------	---	----------------------------	--

FATHER  
FULL NAME William Byron Cotton  
RESIDENCE Shoshone  
COLOR white AGE AT LAST BIRTHDAY 34  
(Years)  
BIRTHPLACE Mich  
OCCUPATION miner

MOTHER  
FULL MAIDEN NAME Viola May Tilton  
RESIDENCE Shoshone  
COLOR white AGE AT LAST BIRTHDAY 29  
(Years)  
BIRTHPLACE Ohio  
OCCUPATION Hom.

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

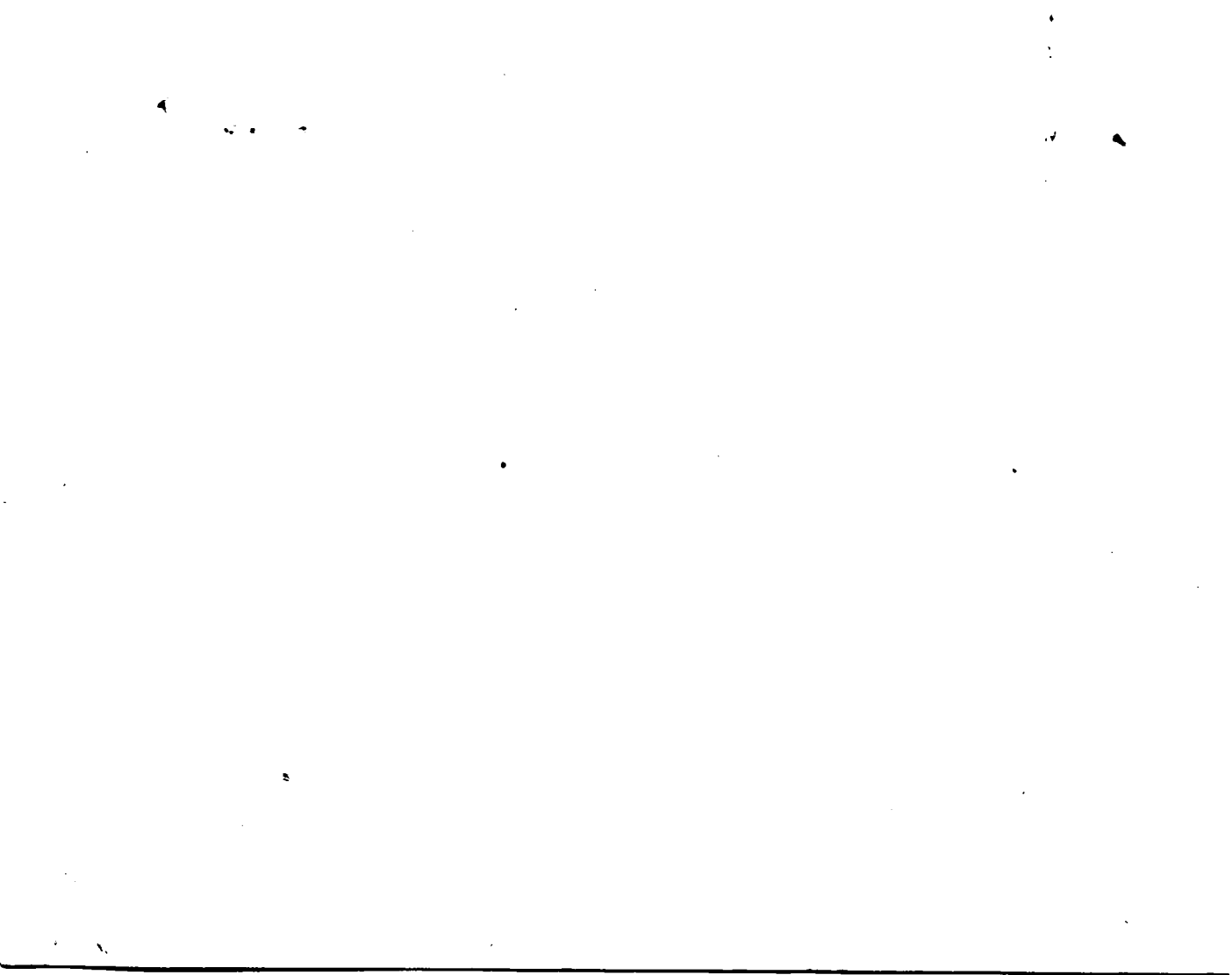
I hereby certify that I attended the birth of this child, who was Still born at 11:30 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. R. Wallington  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Shoshone  
Filed Mich 4 1921 Floyd Wendle  
Registrar



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **32814**  
Registered No. \_\_\_\_\_

## 1. PLACE OF DEATH

County of Sonner  
City of Sandpoint

Registration District No. 78  
Primary Registration District No. 2153  
(No. 713 No. Boyer St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Infant) Cotter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

Jan. 1 - 24 1921  
(Month) (Day) (Year)

## 7. AGE

stillborn  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) Ida.

## 10. NAME OF FATHER

Wm. Cotter.

## 11. BIRTHPLACE OF FATHER

(State or Country) Mich.

## 12. MAIDEN NAME OF MOTHER

Viola Tilton.

## 13. BIRTHPLACE OF MOTHER

(State or Country) Ohio.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Cotter.

(Address) Sandpoint, Ida.

15. Filed Jan 24 1921

Thos. W. Smith  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Jan 1 - 24 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
19   to 19    
that I last saw him alive on stillborn 19    
and that death occurred on the date stated above, at    M.  
The CAUSE OF DEATH\* was as follows:

difficult parturition

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. R. Wallentine M. D.

Jan 19 21 (Address) Sandpoint, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sandpoint, Ida. DATE OF BURIAL Jan. 3, - 21

20. UNDERTAKER B.W. Pugh. ADDRESS Sandpoint, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK: THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

751-103-010-443

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-O-25m-9-27

CERTIFICATE OF BIRTH

S88240

County of Sonneville  
City of Idaho Falls  
No. Basalt St.

Registration District No. ....

File No. .... 32713...

Primary Registration District No. .... 2150

Registered No. .... 30

Hospital .....

FULL NAME OF CHILD .....

Peasley

Sex of Child Male Twin - Triplet - or other? - and { Number in order of birth - } Legitimate? yes Date of Birth Feb. 3 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FULL NAME Allen Peasley FATHER  
RESIDENCE Idaho Falls, Idaho  
COLOR White AGE AT LAST BIRTHDAY 41 (Years)  
BIRTHPLACE Sand Lake, Mich.  
OCCUPATION Mail Carrier

FULL MAIDEN NAME Effie Dutton MOTHER  
RESIDENCE Idaho Falls, Idaho  
COLOR White AGE AT LAST BIRTHDAY 33 (Years)  
BIRTHPLACE Cedar City, Utah.  
OCCUPATION Housewife

Number of child of this mother, including present birth..... 4

Number of children of this mother now living, including present birth..... 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was.....  
on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) .....

Still born HP  
(Born alive or not (lborn))  
L. W. Pendleton  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address .....

Filed 2/7 1921

Registrar

Registrar

du



215-129-012-795

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSS 88254  
32727County of ButteCity of Moore

RECEIVED CERTIFICATE OF BIRTH

Registration District No. 59

File No. \_\_\_\_\_

No. \_\_\_\_\_

BUREAU OF  
STATISTICS

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

SavariaSex of  
ChildMTwin  
Triplet  
or other?

{ and }

Number  
in order  
of birthLegiti  
mate?Yes.Date of  
Birth3-29-1921  
(Month) (Day) (Year)

(To be answered only in event of plural births)

FULL  
NAMEWalter H. Savaria

FATHER

FULL  
MAIDEN  
NAMEMuriel Green

MOTHER

RESIDENCE

Moore

RESIDENCE

Moore

COLOR

NAGE AT LAST  
BIRTHDAY44  
(Years)

COLOR

WAGE AT LAST  
BIRTHDAY30  
(Years)

BIRTHPLACE

Wis

BIRTHPLACE

Utah

OCCUPATION

Farmer

OCCUPATION

UsefulNumber of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 4

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Dead, at 1:00 M.  
on the date above stated. (Born alive or stillborn){ When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth. }

(Signature)

A. McManon

(Physician or midwife)

Given names added from a supplemental report.

19

Address

used

Filed

3/31/21

19

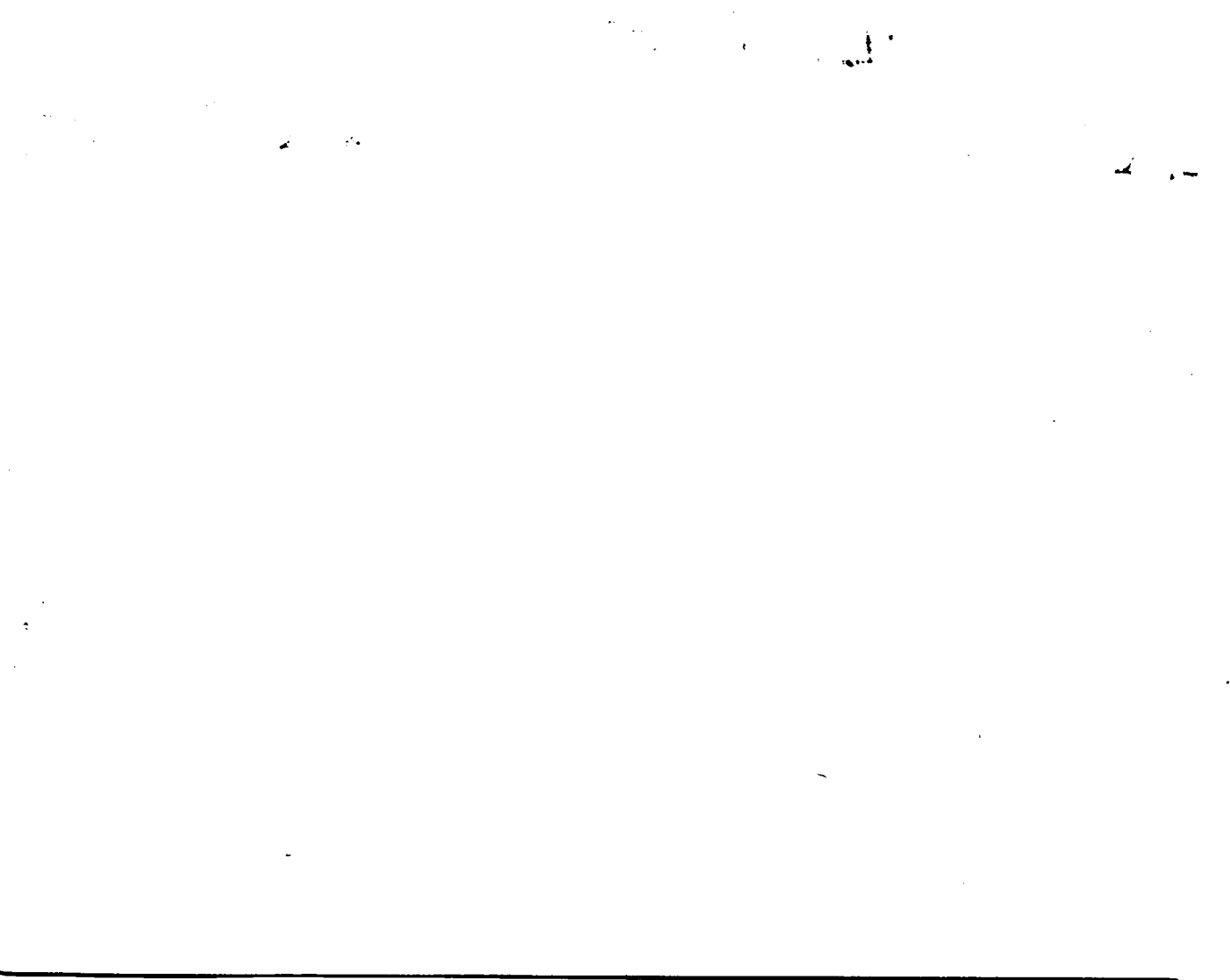
Cannon  
9.

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

RECEIVED

CERTIFICATE OF DEATH

County of *Butte* Registration District No. *87*  
 City of *Moore* Primary Registration District No. *2129*  
 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Still Birth Savaria*

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. *33372*  
 Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *N* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

6. DATE OF BIRTH *3-29-21*  
 (Month) (Day) (Year)

7. AGE \_\_\_\_\_ IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER *Physis M. Savaria*

11. BIRTHPLACE OF FATHER *Wis*  
 (State or Country)

12. MAIDEN NAME OF MOTHER *Muriel Green*

13. BIRTHPLACE OF MOTHER *Wash*  
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. M. Savaria*  
 (Address) *Moore*

15. Filed \_\_\_\_\_ 19 \_\_\_\_\_  
*A. M. Savaria*  
 Local Registrar

16. DATE OF DEATH *3-29-21*  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *3-29-1921* to *3-29-1921*  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
 and that death occurred on the date stated above, at \_\_\_\_\_ M.  
 The CAUSE OF DEATH\* was as follows:

*Still Birth*

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *A. M. Savaria* M. D.  
 3/30/21 (Address) *Arco, Ida.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Moore* DATE OF BURIAL *3/30-1921*

20. UNDERTAKER *Savaria* ADDRESS *Moore*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

546-204-013-619

Form V. S. No. 11-C-22a-8-8-17

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

S 88259

County of Banner.....City of Fairfield.....Registration District No. 58<sup>th</sup>.....File No. 32732.....No. 1.....St.Primary Registration District No. 2138.....

Registered No. ....

Hospital .....

FULL NAME OF CHILD .....

Edwards

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth <u>Feb 4<sup>th</sup> 1921</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	--

FULL NAME <u>Jack I Edwards</u>	FATHER	FULL MAIDEN NAME <u>Maggie Wardrop</u>	MOTHER
RESIDENCE <u>Fairfield, Idaho</u>		RESIDENCE <u>Fairfield, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>Pennsylvania</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 8<sup>th</sup>..... Number of children of this mother now living, including present birth 5.....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born at 9<sup>30</sup> A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) I Wilencheer

(Physician or midwife)

Given names added from a supplemental report.

Address Fairfield, IdahoFiled 2-11 1921

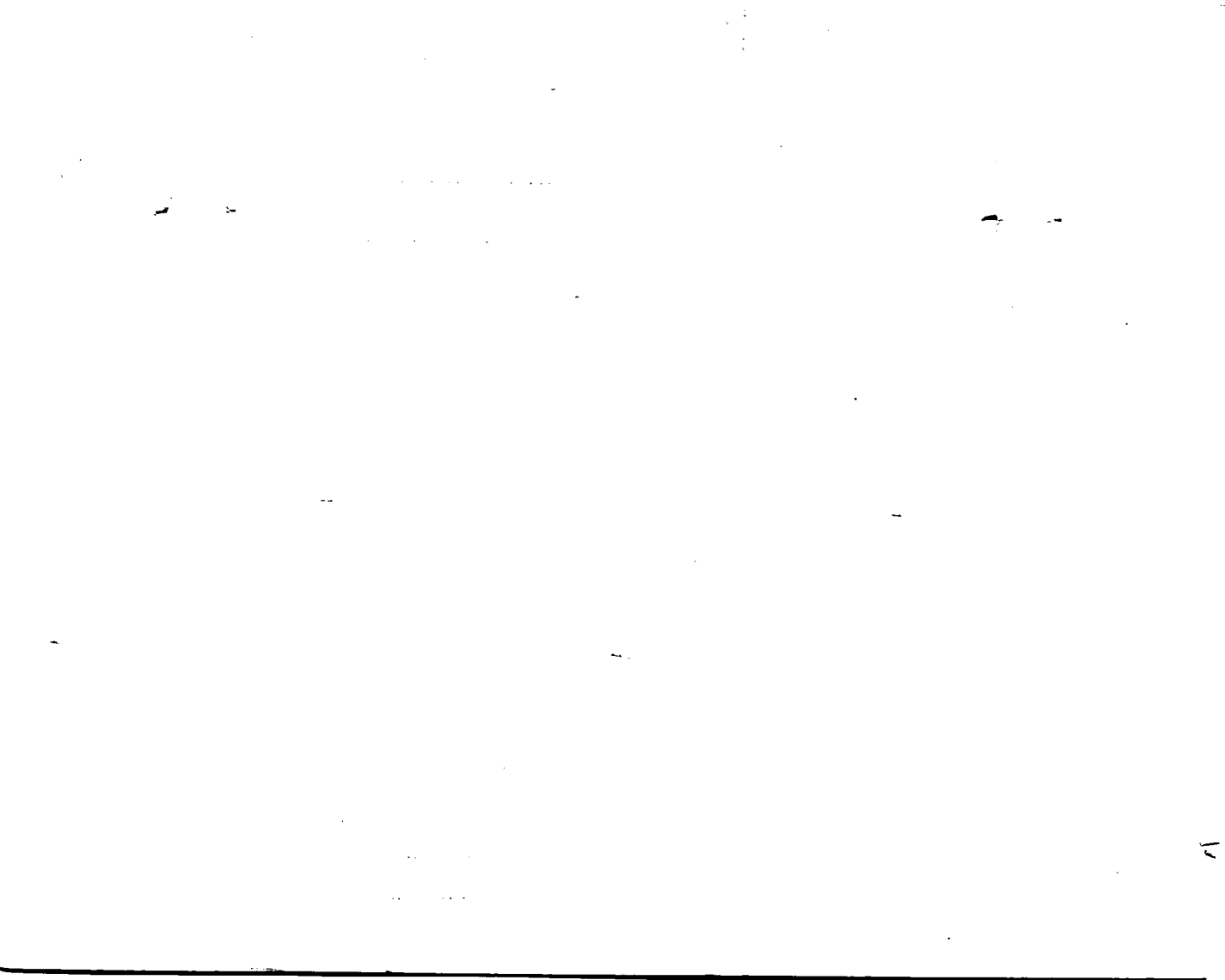
Registrar

Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Camas  
City of FairfieldRegistration District No. 58<sup>d</sup>  
Primary Registration District No. 2138  
(No. \_\_\_\_\_, St.)File No. 33377  
Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

(No name) — Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED

Femalewhitesingle  
(Write the word.)

## 6. DATE OF BIRTH

Feb. 4 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. da.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Camas Co., Idaho

## 10. NAME OF FATHER

Jack L. Edwards

## 11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

## 12. MAIDEN NAME OF MOTHER

Maggie Wardrop

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jack L. Edwards

(Address)

Fairfield, Idaho

## 15.

Filed

3-9 1921L. Wilencheer  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb. 4<sup>th</sup> 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Dead before to 19  
that I last saw h. alive on 19  
and that death occurred on the date stated above, at 9:29 M.

The CAUSE OF DEATH\* was as follows:

Still-born (7 months gestation)

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. Wilencheer M. D.3-9-1921 (Address) Fairfield, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Soldier, Idaho

## DATE OF BURIAL

7-6 1921

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

268-226-014-851

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 88273

County of Canyon

City of Wilder

APR 1 1921  
BUREAU OF VITAL STATISTICS  
Registration District No. 3

File No. 32746

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital Harm

Primary Registration District No. 2005 Registered No. 71

FULL NAME OF CHILD

Sex of Child <u>Female</u>	Twin Triplet or other? _____ and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>Mar 26</u> 19 <u>21</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

FATHER  
FULL NAME A. W. Boyles  
RESIDENCE Wilder Ida  
COLOR White AGE AT LAST BIRTHDAY 35 (Years)  
BIRTHPLACE Wayne Co Ill  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Henrietta Hearn  
RESIDENCE Wilder Ida  
COLOR White AGE AT LAST BIRTHDAY 30 (Years)  
BIRTHPLACE Lamar Co Colo.  
OCCUPATION Housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

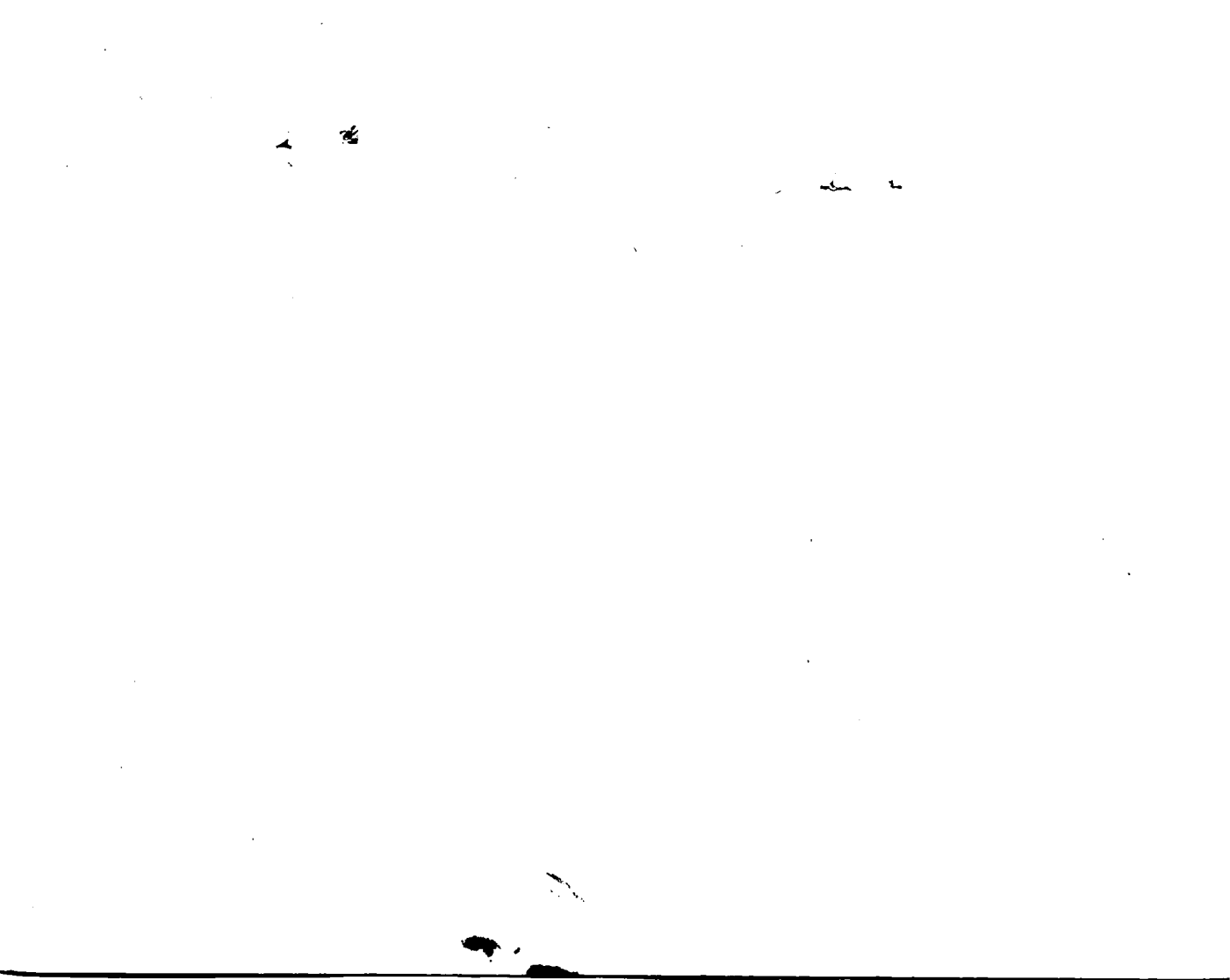
I hereby certify that I attended the birth of this child, who was still born, at 7 A M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. B. Branch  
M. R.  
(Physician or midwife)

Given names added from a supplemental report.

Address Wilder Ida  
Filed April 2-1921 John V. Meyer  
(April) Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 2005City of Wilder(No. APR 11 1921)

St.)

File No. 33383Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Broyles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant  
(Write the word.)

6. DATE OF BIRTH.

Mar  
(Month)26  
(Day)1921  
(Year)

7. AGE

StillbornIF LESS than 1 day  
how many ..... hrs. or  
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....Infant

9. BIRTHPLACE

(State or Country)

Wilder Ida

10. NAME OF FATHER

A. D. Broyles

11. BIRTHPLACE OF FATHER

(State or Country)

Wayne Co Ill

12. MAIDEN NAME OF MOTHER

Henrietta Hearn

13. BIRTHPLACE OF MOTHER

(State or Country)

Lamar Co Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

A. B. Bouch

(Address)

Wilder Ida

15.

Filed

March 28 1921J. L. Bouch

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar  
(Month)26  
(Day)1921  
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 24 1921 to191

that I last saw him alive on

191

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration)

Yrs.

mos.

ds.

Contributory  
(Secondary)Strangulated cord

(Duration)

Yrs.

mos.

ds.

(Signed)

A. B. Bouch M. D.

19..... (Address)

Wilder Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or

usual residence .....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilder Ida3/28 1921

20. UNDERTAKER

ADDRESS

C. D. BouchCaldwell

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

864-108-014-663

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 88367

County of CanyonCity of CaldwellRegistration District No. 9 File No. 89830No. 211 S. 18" St.Primary Registration District No. 1005 Registered No. 58

Hospital \_\_\_\_\_

## FULL NAME OF CHILD

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? Yes	Date of Birth <u>Mar 8</u> 19 <u>21</u> (Month) (Day) (Year)
--------------	--	-----	--------------------------	-----------------	---

FATHER  
FULL NAME Wilber Edward Youmans  
RESIDENCE 211 S. 18" St. Caldwell, Idaho  
COLOR White AGE AT LAST BIRTHDAY 32 (Years)  
BIRTHPLACE Ontario, Canada  
OCCUPATION Machinist

MOTHER  
FULL MAIDEN NAME Sarah Marie Wolfe  
RESIDENCE 211 S. 18" St. Caldwell, Idaho  
COLOR White AGE AT LAST BIRTHDAY 21 (Years)  
BIRTHPLACE Nebraska  
OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 4 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. W. Valey  
M.D.  
(Physician or midwife)

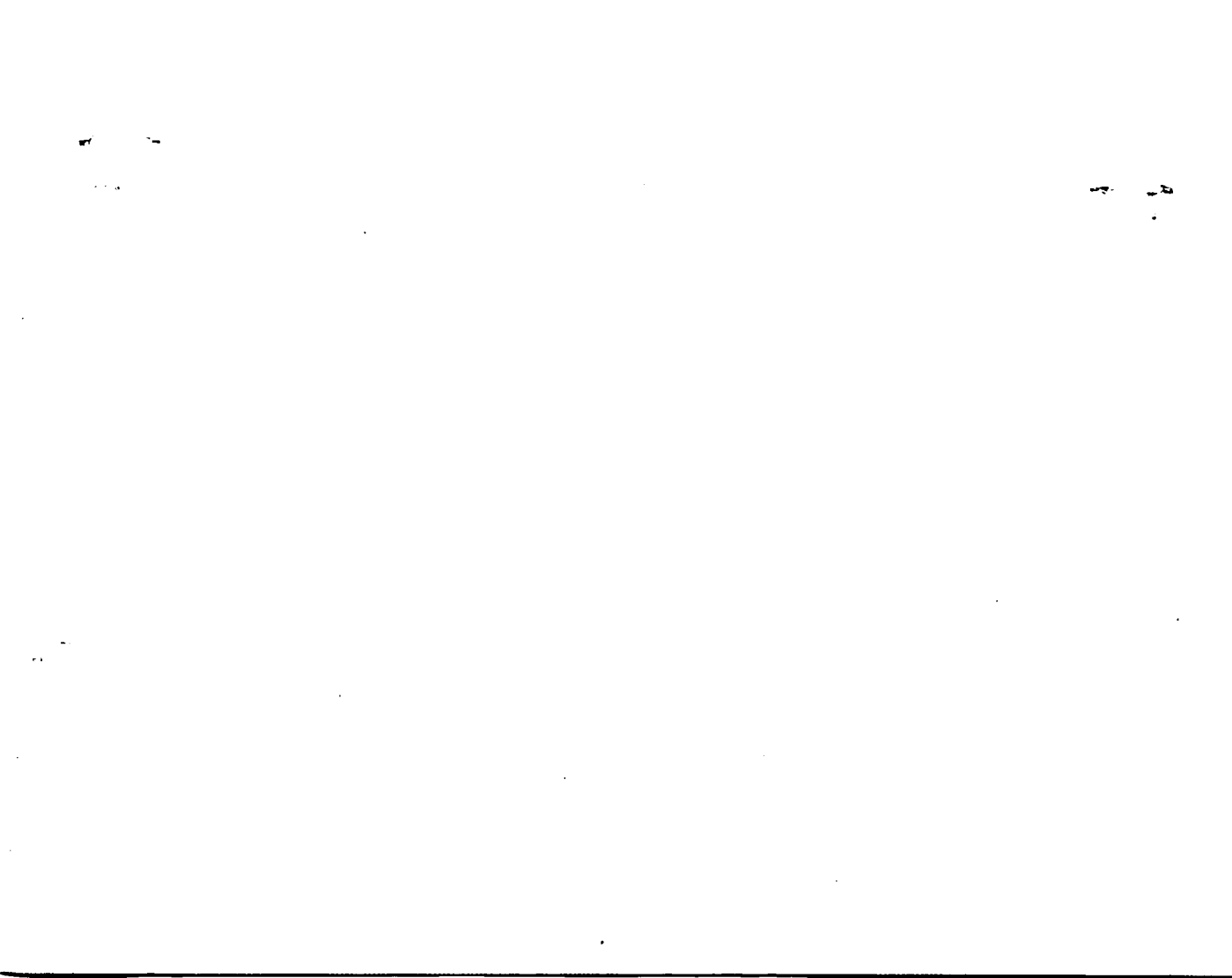
Given names added from a supplemental report.

19

Address Caldwell, Idaho  
Filed Mar. 10 1921 John H. Meyer  
Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Canyon  
City of CaldwellRegistration District No. 3-  
Primary Registration District No. 1005  
(No. \_\_\_\_\_ St.)File No. 33411  
Registered No. 37If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

## 2. FULL NAME

Baby YoumansIf death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDmale white (Write the word.)

## 6. DATE OF BIRTH

March 8 1921  
(Month) (Day) (Year)

## 7. AGE

If LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work.  
(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer).

## 9. BIRTHPLACE

(State or Country) Idaho10. NAME OF  
FATHERW. E. Youmans11. BIRTHPLACE  
OF FATHER(State or Country) Canada12. MAIDEN NAME  
OF MOTHERSarah Marie Wolf13. BIRTHPLACE  
OF MOTHER(State or Country) Nebraska

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Youmans  
(Address) 211 So 18th15. Mar. 9 - 21 John H. Meyer  
Filed Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

March 8 1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased from  
Nov. 8 1921 to Mar 8 1921.

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_.

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory (Secondary) Rephritis in Mother

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

3-10-21 (Address) Caldwell Id\*State the Disease Causing Death, or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted  
if not at place of death?Former or  
usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Canyon Hill 3-9 1921

## 20. UNDERTAKER ADDRESS

E. V. Peckham Caldwell Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



556-227-022-813

Form V. S. No. 11-C-25m-7-21-19

OF BIRTH

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

S 88408

RECEIVED

APR - 4 1921

CERTIFICATE OF BIRTH

County of TremontCity of DrummondBUREAU OF VITAL  
STATISTICS

102

File No. 1No. St.Primary Registration District No. 6Registered No. 56

Hospital

FULL NAME OF CHILD

(Stillborn) NewbySex of Child LTwin  
Triplet  
or other?and Number  
in order  
of birthLegiti  
mate?Date of Birth 3-27 1921  
(Month) (Day) (Year)

(To be answered only in event of plural births)

FULL  
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

BIRTHPLACE

OCCUPATION

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth 8 Number of children of this mother now living, including present birth 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2:45 PM  
on the date above stated. (Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

Address

Filed

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 23453

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED

Registration District No.

APR - 4 1921

Primary Registration District No.

BUREAU OF VITAL STATISTICS

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 / 27 / 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

1892

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

665-101-016-284  
PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-3-37

**S** 88414

County of Assia

City of Burley

Registration District No. 117

File No. 32863

No. St.

Primary Registration District No. 2196

Registered No. 1839

Hospital

FULL NAME OF CHILD Burley Owens

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth <u>Feb. 1 - 1913</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

FULL NAME <u>Wm. F. Owen Jr.</u>	FATHER
RESIDENCE <u>Burley, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>41</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Edith Shortliff</u>	MOTHER
RESIDENCE <u>Burley, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Wife</u>	

Number of child of this mother, including present birth. 6th Number of children of this mother now living, including present birth. 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Edith Owen at 1:15 P. M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. H. Hunter  
M.D.  
(Physician or midwife)

Given names added from a supplemental report.

Address Burley, Idaho

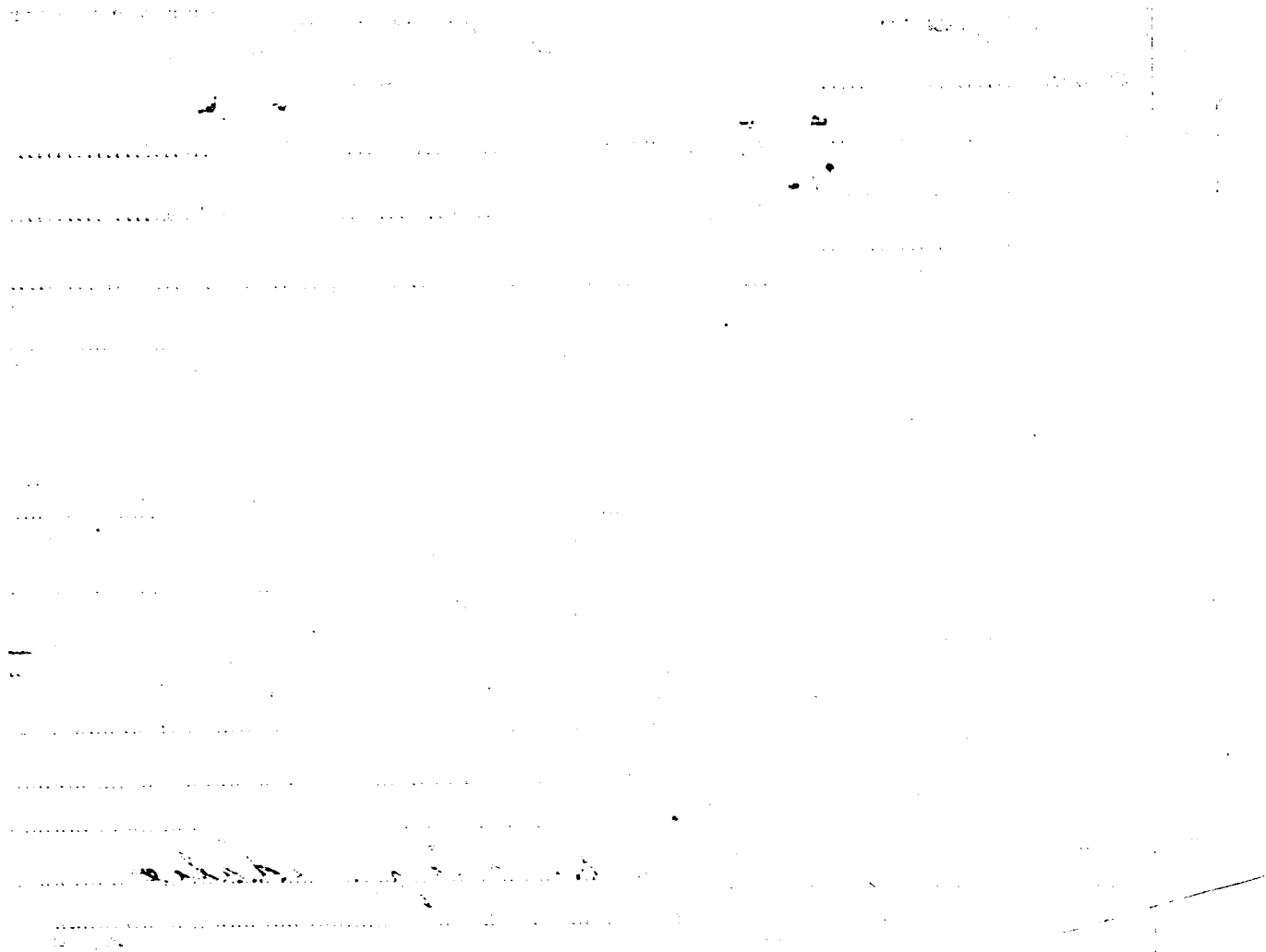
Address Burley, Idaho

Filed Mar. 1st 1913

Filed Mar. 1st 1913

Registrar

Registrar



## 1. PLACE OF DEATH

County of *Cassia*City of *Burley*

If death occurs away from usual residence, give facts called for under special information.

## CERTIFICATE OF DEATH

Registration District No. ....

Primary Registration District No. *2196*

(No. .... St.)

## 2. FULL NAME

*Stillborn*State of Idaho  
BOARD OF HEALTH

Bureau of Vital Statistics

File No. *33433*Registered No. *282*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day  
how many .... hrs. or  
..... min.?

Yrs. .... Mos. .... ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)*Stillborn*

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*H. F. Owen*

11. BIRTHPLACE OF FATHER

(State or Country)

*Utah*

12. MAIDEN NAME OF MOTHER

*Edith Shurtliff*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Utah*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*H. F. Owen  
Burley, Ida.*

15.

Filed *Mar. 3, 1921**D. J. C. Patterson*  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191.....

to

191.....

that I last saw h..... alive on ..... 191.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... Yrs. .... mos. .... ds.

(Signed) *J. H. Hester* M. D.

..... 19..... (Address)

*Burley*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place ..... In the .....  
of death ..... yrs. .... mos. .... days, State ..... yrs. .... mos. .... days

Where was disease contracted

if not at place of death? .....

Former or  
usual residence .....

19. PLACE OF BURIAL OR REMOVAL

*Burley, Ida.*

DATE OF BURIAL

*Feb. 1, 1921*

20. UNDERTAKER

ADDRESS

189 B

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoncum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Aleasles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



619-212-016-249

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25a-4-4-17

S 88418

County of... Cassia .....City of... Burley .....Registration District No. 117 .....File No. 38807 .....

No. .... St. ....

Primary Registration District No. 2196 .....Registered No. 18325 .....

Hospital .....

FULL NAME OF CHILD Baby W. Warren - Stillborn .....

Sex of Child <u>Female</u>	Twin Triplet or other? <u>    </u>	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth <u>Feb 13</u> 191 <u>2</u> (Month) (Day) (Year)
----------------------------	--	--------------------------------------	-----------------------------	---

FULL NAME <u>A. C. Warren</u>	FATHER	FULL MAIDEN NAME <u>Jeannette Smith</u>	MOTHER
RESIDENCE <u>Burley, Idaho</u>		RESIDENCE <u>Burley, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farming</u>		OCCUPATION <u>Surf.</u>	

Number of child of this mother, including present birth... 6 .... Number of children of this mother now living, including present birth... 0 ....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still Born ....., at 4:30 P.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Hutton .....

M.D. .....

(Physician or midwife)

Given names added from a supplemental report.

Address Burley, Idaho .....

Filed Mar 1, 1921 W. J. C. Patterson .....

Registrar

1. *Phragmites australis* (Cav.) Trin. ex Steud.

100

1. *Chlorophyll a* and *Chlorophyll b* were determined by the method of Arar and Collins (1971) using a Shimadzu 1010 spectrophotometer.

... ..

66

[illegible]

1. PLACE OF DEATH  
County of *Cassia*  
City of *Burley*  
If death occurs away from  
usual residence, give facts  
called for under special  
information.

## CERTIFICATE OF DEATH

Registration District No. *7*  
Primary Registration District No. *2196*  
(No. ...., ..... St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *33484*  
Registered No. *33484*  
If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## 2. FULL NAME

*Stallborn*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.  
*Single*  
(Write the word.)

6. DATE OF BIRTH *Feb 28 1921*  
(Month) (Day) (Year)

7. AGE  
..... Yrs. .... Mos. .... ds.  
IF LESS than 1 day  
how many .... hrs. or  
..... min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which em-  
ployed (or employer)

*Stallborn*

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*A.C. Harrison*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Utah*

## 12. MAIDEN NAME OF MOTHER

*Jeannette Smith*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Utah*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A.C. Harrison*  
(Address) *Burley, Ida*

15. Filed *Mar 1 1921*

*Dr. J. C. Baller*  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Stallborn* 191.....  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
191..... to 191.....

that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

*Stallborn*

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... Yrs. .... mos. .... ds.

(Signed) *F. H. Culler* M. D.

19..... (Address) *Burley*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place ..... In the  
of death ..... yrs. .... mos. .... days, State ..... yrs. .... mos. .... days

Where was disease contracted

If not at place of death? .....

Former or  
usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

*Burley Ida*

## DATE OF BURIAL

*Feb 12, 1921*

## 20. UNDERTAKER

ADDRESS

18915

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia*, *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

415-121-018-515

## PLACE OF BIRTH

County of

Clearwater

City of

Carandish

No.

St.

Hospital

Primary Registration District No.

File No.

Registered No.

FULL NAME OF CHILD

(John Doe) Daniels

Sex of Child

Boy

Twin  
Triplet  
or other

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti  
mate?

Yes

Date of Birth

3/21 1921  
(Month) (Day) (Year)

FULL NAME

Jim S. Daniels

FATHER

FULL MAIDEN NAME

Ethel Mary Van Caudish

MOTHER

RESIDENCE

Carandish

RESIDENCE

Carandish

COLOR

White

AGE AT LAST BIRTHDAY

26  
(Years)

COLOR

White

AGE AT LAST BIRTHDAY

27  
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Labour

OCCUPATION

Housewife

Number of child of this mother, including present birth

3

Number of children of this mother now living, including present birth

3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was

Still born  
(Born alive or stillborn)

at 10 A.M.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. M. Maxwell  
Regina J. J. J.  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

19

Registrar

Registrar

RECEIVED

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

RECEIVED

APR 7 1921

CERTIFICATE OF BIRTH

BUREAU OF VITAL

STATISTICS

Form V. S. No. 11-C-25m-7-21-19

S 88461

90

21/8

19

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

22

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.....  
County of Clearwater Registration District No. 90  
City of Carnadish Primary Registration District No. 2168  
And APR 7 1921 St.)

File No. 33413Registered No. ....  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (John Doe) Daniels

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)6. DATE OF BIRTH 3/21/1921  
(Month) (Day) (Year)7. AGE Steelborn mos. ds.  
IF LESS than 1 day how many ..... hrs. or mins.?8. OCCUPATION  
(a) Trade, profession or particular kind of work .....  
(b) General nature of industry business, or establishment in which employed (or employer) .....9. BIRTHPLACE Carnadish Ida  
(State or Country)10. NAME OF FATHER Jim Daniels11. BIRTHPLACE OF FATHER Idaho  
(State or Country)12. MAIDEN NAME OF MOTHER Ethel May Vautinsdale13. BIRTHPLACE OF MOTHER Idaho  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ethel M. Vautinsdale(Address) Orford15. Filed Apr 4 1921 St. John  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 3/21/1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 3/21 1921, to 3/21 1921, that I last saw him alive on Steelborn 191, and that death occurred on the date stated above, at 10 AM.  
The CAUSE OF DEATH\* was as follows:  
Premature labor - Labor induced for Placenta Previa centralis  
(Duration) ..... yrs. .... mos. .... ds.  
Contributory (Secondary) .....  
(Duration) ..... yrs. .... mos. .... ds.  
(Signed) Ethel M. Vautinsdale M. D.  
3/21 1921 (Address) Orford Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

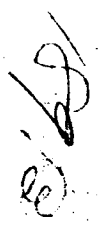
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days.  
Where was disease contracted if not at place of death? .....  
Former or usual residence .....19. PLACE OF BURIAL OR REMOVAL Carnadish Ida DATE OF BURIAL 3/21 192120. UNDERTAKER noneADDRESS -

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."





867-127-026-049  
PLACE OF BIRTH

Form V. S. No. 11-20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 88554

County of JeffersonCity of RegleyRegistration District No. 78File No. 28807

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2176Registered No. 14

Hospital \_\_\_\_\_

FULL NAME OF CHILD TheobornSex of Child M.Twin  
Triplet  
or other?   

and

Number  
in order  
of birth   Legiti-  
mate? Yes.Date of  
Birth Feb 27

(Month)

(Day)

1921  
(Year)

(To be answered only in event of plural births)

FULL NAME

FATHER

Warren W. Hope

RESIDENCE

Regley -

COLOR

M -AGE AT LAST  
BIRTHDAY30  
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer.FULL  
MAIDEN  
NAME

MOTHER

Mildred Finke

RESIDENCE

Regley Ida.

COLOR

WAGE AT LAST  
BIRTHDAY31  
(Years)

BIRTHPLACE

England

OCCUPATION

HousewifeNumber of child of this mother, including present birth 4Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.Stillborn 8 P.

(Born alive or stillborn)

(Signature)

Ray H. Gibe.

(Physician or midwife)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

Given names added from a supplemental report.

19

Address

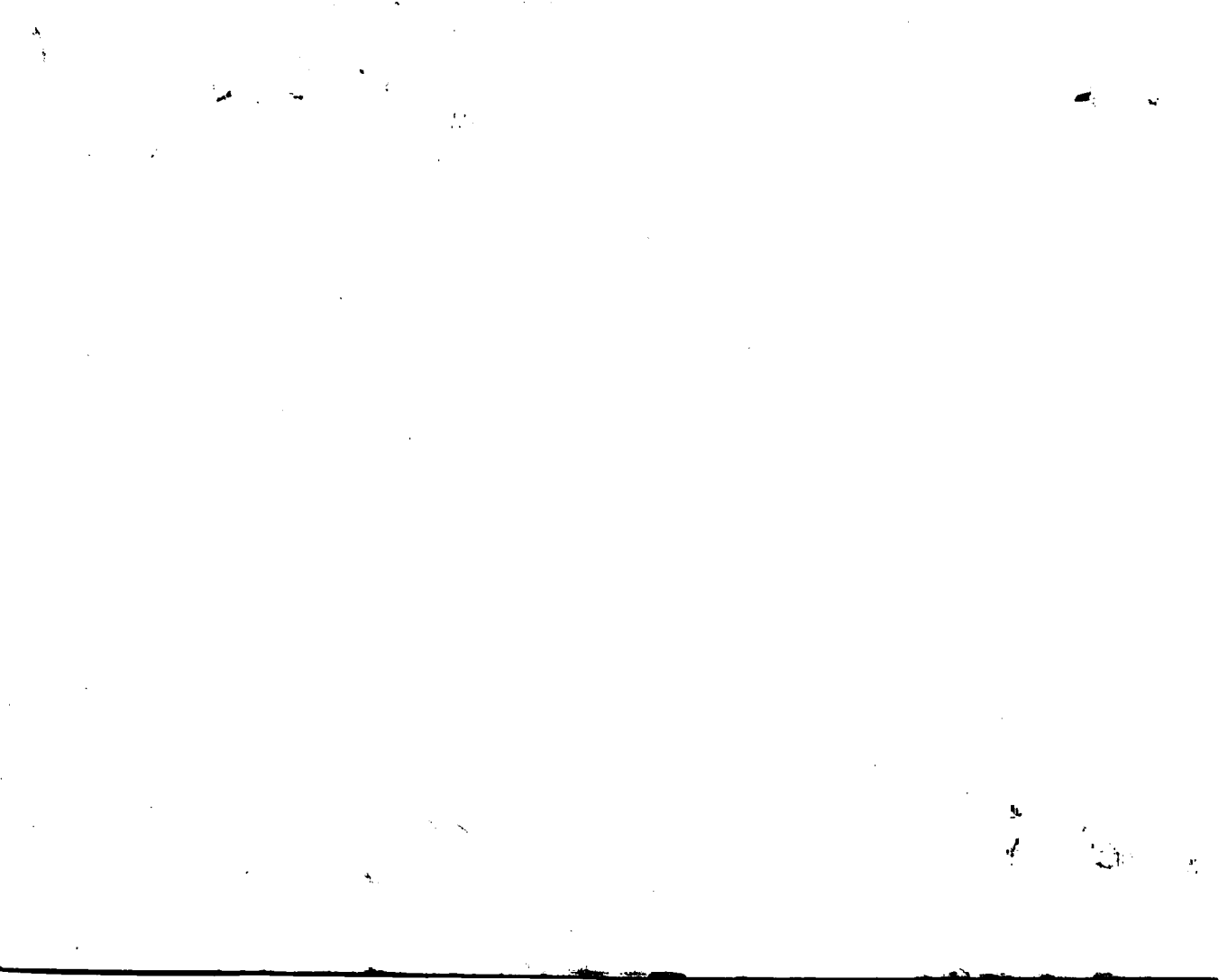
Regley Ida.

Filed

McK 10 19 21

Registrar.

Registrar.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Jefferson  
City of RegleyRegistration District No. 78Primary Registration District No. 2176

(No. \_\_\_\_\_ St.)

File No. 33457Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baley Hope

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

M.

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

Feb 28 1921  
(Month) (Day) (Year)

## 7. AGE

Steelborn  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Ida.

## 10. NAME OF FATHER

Warren W Hope

## 11. BIRTHPLACE OF FATHER

(State or Country)

Utah

## 12. MAIDEN NAME OF MOTHER

Mildred Turner

## 13. BIRTHPLACE OF MOTHER

(State or Country)

England

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Warren W Hope  
Regley, Ida.

## 15.

Filed

Mch 10 1921 Ray & Gish  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb 27 21  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Feb 27 1921 to Feb 27 1921

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Steelborn  
Proaloped cord.  
(Duration) Version mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ray & Gish M. D.  
Regley, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Ucon. Mch 1 1921

## 20. UNDERTAKER

## ADDRESS

Fredericks Regley, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

766-114-028-815  
PLACE OF BIRTH

County of Kootenai  
City of Post Falls

RECEIVED STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
APR 7 1921  
BUREAU OF VITAL STATISTICS  
Registration District No. 30

Form V. S. No. 11—25m-9-8-15

S88588

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 1057

File No. \_\_\_\_\_  
Registered No. 924

Hospital \_\_\_\_\_  
FULL NAME OF CHILD (not named) Goodwin

Sex of Child <u>male</u>	Twin Triplet or other? <u>-</u> and (Number in order of birth) <u>-</u>	Legitimate? <u>yes</u>	Date of Birth <u>Mar 14 1921</u> (Month) (Day) (Year)
FATHER FULL NAME <u>Harry J. Goodwin</u> RESIDENCE <u>Post Falls</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>28</u> (Years) BIRTHPLACE <u>Ark.</u> OCCUPATION <u>Farmer</u>		MOTHER FULL MAIDEN NAME <u>Alta Hanna</u> RESIDENCE _____ COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>28</u> (Years) BIRTHPLACE <u>Mo.</u> OCCUPATION <u>House-keeper</u>	

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at the date above stated.

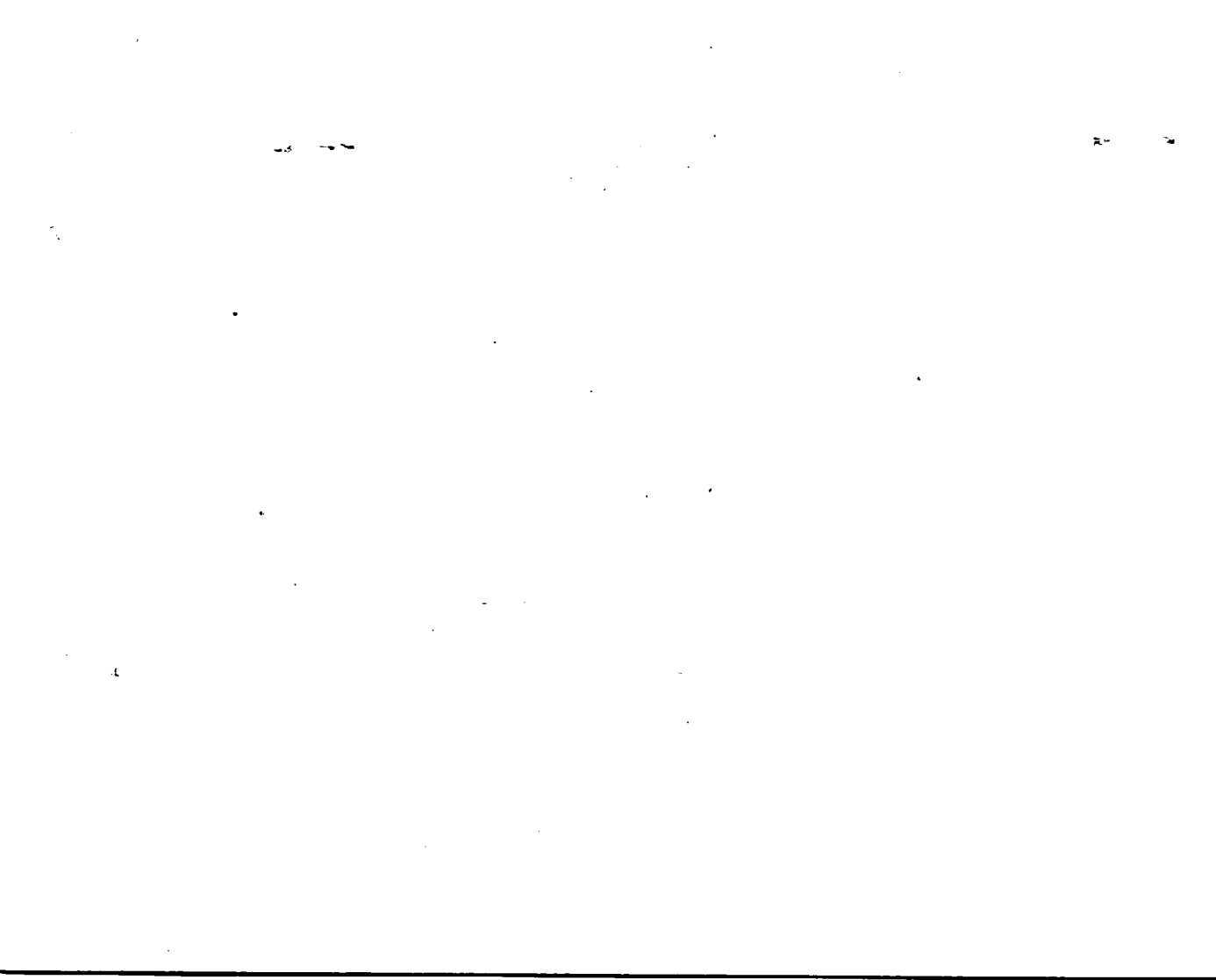
Still born at 2:30 P. M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. L. McCauley  
(Physician or midwife)

Given names added from a supplemental report.

Address Post Falls, Idaho  
Filed April 4 1921 D. D. Brennan  
Registrar



FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED

APR 7 1921

CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of

Dootenai  
Post Falls

BUREAU OF VITAL

Registration District No.

30

STATISTICAL Registration District No.

1257

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

(unnamed) Goodwin

State of Idaho

BOARD OF HEALTH

Bureau of Vital Statistics

File No. 33489

Registered No. 879

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

white

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

Single

## 6. DATE OF BIRTH.

Still-born  
Mar 14 1921

(Month)

(Day)

(Year)

## 7. AGE

Still-born

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or  
min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

Harry J Goodwin  
Arkansas

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

Alta Hanna

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry J. Goodwin  
Post Falls, Ida

## 15.

Filed

Apr 4 1921

D.D. Drennon

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Still-born on  
Mar 14 1921

(Month)

(Day)

(Year)

## 17.

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him

Still-born

191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still-born

(Duration)

Yrs.

mos.

ds.

Contributory  
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

F. L. McCauley  
3/14 1921 (Address) Post Falls Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted  
if not at place of death?

Former or

usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Mar 14 1921

## 20. UNDERTAKER

own.

acted as my  
Harry Goodwin

## ADDRESS

18913

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer; Physician; Stenographer; Composer; Architect; Locomotive engineer; Civil engineer; Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoncum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms. *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



418 - 110 - 029 - 314

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-22m-3-8-17

County of Latah

RECEIVED

CERTIFICATE OF BIRTH

S 88649  
33123

City of Genesee

APR 6 1921

Registration District No.

File No.

No.

BUREAU OF VITAL

STATISTICS

Primary Registration District No.

Registered No.

Hospital

FULL NAME OF CHILD Baby Mayer

Sex of Child <u>M</u>	Twin Triplet or other? <u>  </u>	and { Number in order of birth <u>  </u> }	Legitimate? <u>yes</u>	Date of Birth <u>3 10 1921</u> (Month) (Day) (Year)
-----------------------	----------------------------------	--	------------------------	--

FATHER  
FULL NAME Arthur Mayer  
RESIDENCE Genesee  
COLOR W AGE AT LAST BIRTHDAY 19  
(Years)  
BIRTHPLACE Minn.  
OCCUPATION Mechanic

MOTHER  
FULL MAIDEN NAME Anna Lambert  
RESIDENCE Genesee - Ida.  
COLOR W AGE AT LAST BIRTHDAY 17  
(Years)  
BIRTHPLACE Genesee - Ida.  
OCCUPATION Housewife

Number of child of this mother, including present birth... 1 ... Number of children of this mother now living, including present birth... 0 ...

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn, at 15<sup>th</sup> A on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. P. ... M.D.

(Physician or midwife)

Given names added from a supplemental report.

.....19.....

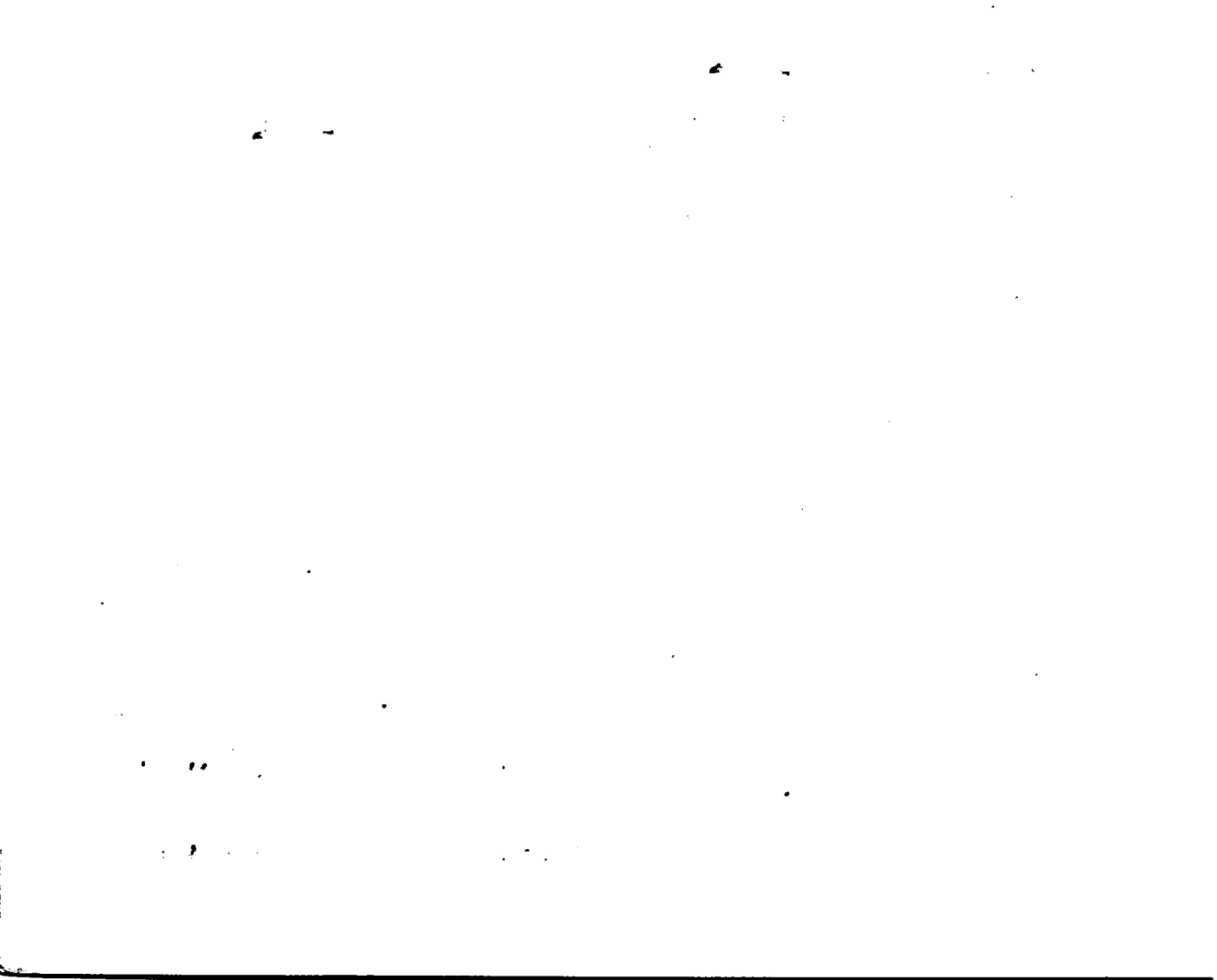
Address.....

.....

Filed 3-14-21 L. A. ...

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—ALWAYS AS A REGULATION IN A N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

Registration District No. *52*County of *Latah*

RECEIVED

Primary Registration District No. *2142*City of *Genesee*

APR 10 1921

St.)

File No. *33508*Registered No. *33508*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

BUREAU OF VITAL STATISTICS

*Baby**Mayer*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*M*

## 4. COLOR OR RACE

*W*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*Baby*

(Write the word.)

## 6. DATE OF BIRTH.

*3*

(Month)

*10*

(Day)

*1921*

(Year)

## 7. AGE

Yrs. *4*

Mos.

ds.

IF LESS than 1 day  
how many.....hrs. or  
.....min.)

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country)

*Genesee - Idaho*

## 10. NAME OF FATHER

*Mr. Arthur Mayer*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Minn.*

## 12. MAIDEN NAME OF MOTHER

*Anna Lambert*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Genesee - Ida.*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*H. P. Pouse, M.D.*

(Address)

*Genesee - Idaho.*

## 15.

Filed *3-10-21*

191

*W. H. Pouse*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*3*

(Month)

*10*

(Day)

*1921*

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *3-10-1921* 191, to *3-10-21* 191.that I last saw h.....alive on.....191.....  
and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH\* was as follows:

*Abortion, about four months duration - high fever and severe hemorrhages.*

(Duration).....Yrs.....mos.....ds.

Contributory  
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *H. P. Pouse* M. D.1921 (Address) *Genesee - Idaho.*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted  
if not at place of death?.....Former or  
usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Genesee - Idaho**3/16 1921*

## 20. UNDERTAKER

## ADDRESS

*J. E. Lambert**Genesee - Idaho*

157 a

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

632-116-029-493

## PLACE OF BIRTH

County of LatahCity of BovillNo. # St.Hospital #

FULL NAME OF CHILD

Registration District No. 66File No. 12Primary Registration District No. 2146

Registered No. \_\_\_\_\_

Kent Eugene Olsen

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>Feb. 16</u> 19 <u>21</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-------------------------------	---

FULL NAME <u>Emery Olsen</u>	FATHER
RESIDENCE <u>Deary, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>57</u> (Years)
BIRTHPLACE <u>Minnesota</u>	
OCCUPATION <u>Office man - P. L. Lumber Co.</u>	

FULL MAIDEN NAME <u>Kate G. Miller</u>	MOTHER
RESIDENCE <u>Deary, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)
BIRTHPLACE <u>Illinois</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth <u>7</u>	Number of children of this mother now living, including present birth <u>6</u>
--	--

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born, at 3:30 a.m.  
on the \_\_\_\_\_ day of \_\_\_\_\_, 1921.  
(Born alive or stillborn)

(Signature)

(Born alive or stillborn)

F. C. Gibson

(Physician or midwife)

Physician

Address

Bovill, Idaho

Filed

3/17 1921

Registrar

Mrs F. C. Gibson

Registrar

# REC'D RECORDED FOR BUNDEGE

ALL BIRTHS WITH GIVING IN THIS IS A MARRIAGE RECORD  
 ALL BIRTHS WITH GIVING IN THIS IS A MARRIAGE RECORD  
 ALL BIRTHS WITH GIVING IN THIS IS A MARRIAGE RECORD

PLACE OF BIRTH

DEPARTMENT OF VITAL STATISTICS  
 BUREAU OF VITAL STATISTICS

288628  
 38100

County of \_\_\_\_\_  
 City of \_\_\_\_\_  
 No. \_\_\_\_\_

Registered No. \_\_\_\_\_  
 Birth No. \_\_\_\_\_  
 District No. \_\_\_\_\_

WILL NAME OF CHILD

Sex of Child  
 Male \_\_\_\_\_  
 Female \_\_\_\_\_

FATHER

MOTHER

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

COLOR

AGE AT LAST BIRTHDAY

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  
 Number of child of this mother, including present birth \_\_\_\_\_  
 Number of children of this mother now living, including present birth \_\_\_\_\_

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
 (born alive or stillborn)

(Signature)

Physician or midwife

Signature of mother

10

10

10

10

Registered

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of *Latah*  
City of *Bozell*

RECEIVED  
APR 12 1921  
BUREAU OF VITAL  
STATISTICS

Registration District No. *66*Registration District No. *2146*

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. *33509*

Registered No.

If death occurs away from  
usual residence, give facts  
called for under special  
information.

2. FULL NAME

*Kent Eugene Olsen*

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Male*

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.*Single*  
(Write the word.)

6. DATE OF BIRTH.

*March 16 1921*  
(Month) (Day) (Year)

7. AGE

*0* Yrs. *0* Mos. *0* ds.

IF LESS than 1 day  
how many *0* hrs. or  
*0* min.?

8. OCCUPATION

(a) Trade, profession or  
particular kind of work.  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which employ-  
ed (or employer)

*None*

9. BIRTHPLACE

(State or Country)

*Bozell-Idaho*10. NAME OF  
FATHER*Emery Olsen*11. BIRTHPLACE  
OF FATHER

(State or Country)

*Minnesota*12. MAIDEN NAME  
OF MOTHER*Kate E. Miller*13. BIRTHPLACE  
OF MOTHER

(State or Country)

*Ill.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Emery Olsen*

(Address)

*Bozell, Idaho*

15.

Filed

*3/16/1921*

1921

*Mrs. F. L. Gibson*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*3-16-1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*8-16-1921* to *3-16-1921*that I last saw him alive on *1921*and that death occurred on the date stated above, at *1921* M.

The CAUSE OF DEATH\* was as follows:

*Could not determine cause of death  
which had occurred several days  
before birth. Prolonged gestation - 9 months*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)*Age of mother*

(Duration) Yrs. mos. ds.

(Signed)

*F. L. Gibson*

M. D.

*3/16/1921* (Address) *Bozell Idaho*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)  
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted  
if not at place of death?.....

Former or  
usual residence .....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Bozell, Idaho**3/18/1921*

20. UNDERTAKER

ADDRESS

*None*

189 B

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

648-116-034-5-64

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. 8, No. 11-C, Rev. 5-21-10

S 88748

County of Minidoka

City of Paul

Registration District No. 19

File No. 30000

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2013

Registered No. 28

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Franklin Eugene

Sex of Child male

Twin  
Triplet  
or other?

1 and 1

Number  
in order  
of birth

1  
(To be answered only in event of plural births)

Legiti  
mate?

yes

Date of  
Birth

Feb 16 1921  
(Month) (Day) (Year)

FULL  
NAME

FATHER  
Ward Eugene

RESIDENCE

Paul Ida

COLOR

white

AGE AT LAST  
BIRTHDAY

32  
(Years)

BIRTHPLACE

Andleton Ind

OCCUPATION

bookkeeper

FULL  
MAIDEN  
NAME

MOTHER  
Katherine Voss

RESIDENCE

Paul Ida

COLOR

white

AGE AT LAST  
BIRTHDAY

28  
(Years)

BIRTHPLACE

Idaho, Ill

OCCUPATION

housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

born dead 2-16-21 at 11:50 A. M.  
(Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

W. H. H. H. H. H.  
W. H. H. H. H. H.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Paul Ida

Filed

Mar 3 1921 E. H. H. H. H.

Registrar

Registrar



710

685-113-038-493

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

County of PayetteCity of Payette

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

## FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u> { } <u>in order of birth</u> { } <u>Legitimate?</u> <u>Yes</u>	Date of Birth <u>March</u> <u>13</u> <u>1921</u> (Month) (Day) (Year)
--------------------------	--	--

FATHER  
FULL NAME O. A. WheelerRESIDENCE Payette IdahoCOLOR White AGE AT LAST BIRTHDAY 24  
(Years)BIRTHPLACE Neb.OCCUPATION MachanicMOTHER  
FULL MAIDEN NAME Clara MitchellRESIDENCE Payette IdahoCOLOR White AGE AT LAST BIRTHDAY 17  
(Years)BIRTHPLACE IdahoOCCUPATION HousewifeNumber of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 10:45 A.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. McDonald

(Physician or midwife)

Given names added from a supplemental report.

19

Registrar

Address Payette IdahoFiled Mar 16 19 21Registrar J. C. Woodward

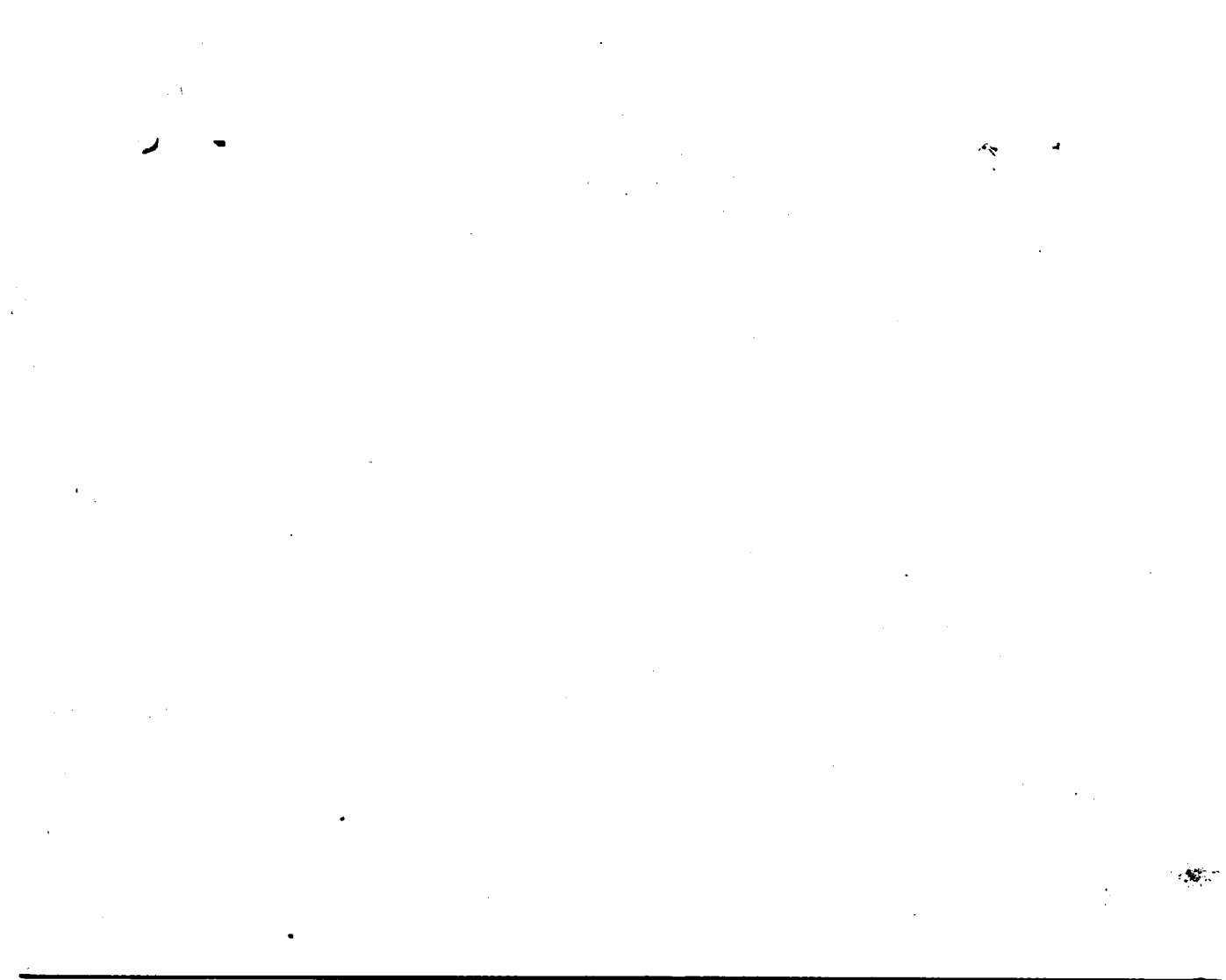
MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
RECEIVED  
APR 1 1921  
BUREAU  
STA

S 88827

Registration District No. 44File No. 33301Primary Registration District No. 1008Registered No. 17



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No.

County of

APR 4 1921 Registration District No.

City of

BUREAU OF VITAL  
STATISTICS

St.)

Registered No.

If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

2. FULL NAME

Baby Wheeler

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

male

white

Single  
(Write the word.)

6. DATE OF BIRTH

Mar  
(Month)13  
(Day)1921  
(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or  
particular kind of work(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)

9. BIRTHPLACE

(State or Country)

Payette Idaho

10. NAME OF  
FATHER

Orville Earl Wheeler

11. BIRTHPLACE  
OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME  
OF MOTHER

Ema Mitchell

13. BIRTHPLACE  
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Orville Earl Wheeler

(Address)

Payette Idaho

15.

Filed

March 14 1921

J. C. Woodward

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March  
(Month)13  
(Day)1921  
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Still Born to Still Born

that I last saw him alive on Still Born

and that death occurred on the date stated above, at 10:45 M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) Yrs. Mos. ds.

Contributory  
(Secondary)

Still Born

(Duration) Yrs. Mos. ds.

(Signed)

J. C. Woodward M. D.

3/13/1921

(Address) Payette Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)At place In the  
of death Yrs. Mos. days. State Yrs. Mos. daysWhere was disease contracted  
if not at place of death?Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho

March 13 1921

20. UNDERTAKER

ADDRESS

Gerrit C Landon

Payette Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

355-223-039-165  
PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—26m-9-8-15

County of Ponier

City of Immer Falls

Registration District No. 25

CERTIFICATE OF BIRTH

File No. 6

**S 88858**  
~~80000~~

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2072

Registered No. 291

Hospital \_\_\_\_\_

FULL NAME OF CHILD

(Stillborn)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u> and <u>—</u> Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of Birth <u>July 23</u> 19 <u>21</u> (Month) (Day) (Year)
FULL NAME <u>FATHER</u> <u>Walter J. Lemmex</u>		FULL MAIDEN NAME <u>MOTHER</u> <u>Stella May Jones</u>	
RESIDENCE <u>Immer Falls</u>		RESIDENCE <u>Same</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Wis.</u>		BIRTHPLACE <u>Ky</u>	
OCCUPATION <u>Laborer</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth. 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ on the date above stated.

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. F. Schiefelbusch at 8302 M.  
(Don't write or stillborn)

Given names added from a supplemental report.

(Physician or midwife)  
Address Am Falls  
Filed 3/25 1921  
Registrar R. F. Work





WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

Registration District No. 25County of PowerPrimary Registration District No. 2072City of Sumner Falls

(No. \_\_\_\_\_) (St. \_\_\_\_\_)

File No. 33573Registered No. 117

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME None

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.Single  
(Write the word.)

## 6. DATE OF BIRTH.

July 23 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. \_\_\_\_\_ Mos. 0 ds. \_\_\_\_\_IF LESS than 1 day  
how many \_\_\_\_\_ hrs. or  
\_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...None

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Walker J. Lemmex

## 11. BIRTHPLACE OF FATHER

(State or Country)

Wis

## 12. MAIDEN NAME OF MOTHER

Stella May Jones

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idy

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

## 15.

Filed 3/25 1921R. F. North

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

July 23 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY That I attended deceased from

Still birth 191 \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 191 \_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still birth

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) A. J. Smith M. D.222 1921 (Address) Sumner Falls, Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

Sumner Falls

## DATE OF BURIAL

2/23 1921

## 20. UNDERTAKER

Family

## ADDRESS

18915

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

415-218-040-413

PLACE OF BIRTH

County

City of

No.

St.

Hospital

FULL NAME OF CHILD

Sex of  
Child

Twins  
Triplet  
or other?  
(To be answered only in event of plural births)

and { Number  
in order  
of birth

Legiti-  
mate?

Date of  
Birth

(Month)

(Day)

(Year)

FATHER  
FULL  
NAME

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

MOTHER  
FULL  
MAIDEN  
NAME

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_, at \_\_\_\_\_, on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Registrar

Address

Filed

1921

Registrar

Form V. S. No. 11-C-25m-7-21-19

RECEIVED STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
APR 5 1921  
CERTIFICATE OF BIRTH

S 88873

BUREAU OF VITAL  
STATISTICS 70

File No.

Registered No.

36

Primary Registration District No.

10 11

Full Name of Child: *George Davis*  
Sex: *M*  
Twins/Triplet/other: *No*  
Number in order of birth: *1st*  
Legitimate: *Yes*  
Date of Birth: *Feb 19 1921*

Father: *George Davis*  
Mother: *Laura Dalton*  
Residence: *Maple*  
Color: *White*  
Age at last birthday: *36*  
Birthplace: *Iowa*  
Occupation: *Mines*

Number of child of this mother, including present birth: *1*  
Number of children of this mother now living, including present birth: *0*  
Certificate of Attending Physician or Midwife:  
I hereby certify that I attended the birth of this child, who was *Male*, at *Maple*, on the date above stated.  
(Born alive or stillborn)  
(Signature) *Dr. M. W. Key*

Given names added from a supplemental report:  
19  
Registrar  
Address: *Feb 28 21 F. L. Jones*  
Filed: *Feb 28 21*  
Registrar

**WAYCROSS REZEARED FOR BINDING.**

to maintaining a high level of security and safety. The following are the key elements of the program:

[illegible]

1. Name of the person or organization: Mr. J. Edgar Hoover  
 2. Address: Washington, D.C.  
 3. City: Washington State: D.C. Zip: 20535  
 4. Country: USA  
 5. Telephone: (202) 456-7890  
 6. Fax: (202) 456-7891  
 7. E-mail: jeh@fbi.gov  
 8. Date of birth: 1-22-1895  
 9. Date of death: 10-6-1972  
 10. Date of capture: 10-6-1972  
 11. Date of release: 10-6-1972  
 12. Date of conviction: 10-6-1972  
 13. Date of sentencing: 10-6-1972  
 14. Date of appeal: 10-6-1972  
 15. Date of final judgment: 10-6-1972  
 16. Date of execution: 10-6-1972  
 17. Date of burial: 10-6-1972  
 18. Date of cremation: 10-6-1972  
 19. Date of interment: 10-6-1972  
 20. Date of exhumation: 10-6-1972  
 21. Date of reburial: 10-6-1972  
 22. Date of reinterment: 10-6-1972  
 23. Date of reexhumation: 10-6-1972  
 24. Date of reburial: 10-6-1972  
 25. Date of reinterment: 10-6-1972  
 26. Date of reexhumation: 10-6-1972  
 27. Date of reburial: 10-6-1972  
 28. Date of reinterment: 10-6-1972  
 29. Date of reexhumation: 10-6-1972  
 30. Date of reburial: 10-6-1972  
 31. Date of reinterment: 10-6-1972  
 32. Date of reexhumation: 10-6-1972  
 33. Date of reburial: 10-6-1972  
 34. Date of reinterment: 10-6-1972  
 35. Date of reexhumation: 10-6-1972  
 36. Date of reburial: 10-6-1972  
 37. Date of reinterment: 10-6-1972  
 38. Date of reexhumation: 10-6-1972  
 39. Date of reburial: 10-6-1972  
 40. Date of reinterment: 10-6-1972  
 41. Date of reexhumation: 10-6-1972  
 42. Date of reburial: 10-6-1972  
 43. Date of reinterment: 10-6-1972  
 44. Date of reexhumation: 10-6-1972  
 45. Date of reburial: 10-6-1972  
 46. Date of reinterment: 10-6-1972  
 47. Date of reexhumation: 10-6-1972  
 48. Date of reburial: 10-6-1972  
 49. Date of reinterment: 10-6-1972  
 50. Date of reexhumation: 10-6-1972  
 51. Date of reburial: 10-6-1972  
 52. Date of reinterment: 10-6-1972  
 53. Date of reexhumation: 10-6-1972  
 54. Date of reburial: 10-6-1972  
 55. Date of reinterment: 10-6-1972  
 56. Date of reexhumation: 10-6-1972  
 57. Date of reburial: 10-6-1972  
 58. Date of reinterment: 10-6-1972  
 59. Date of reexhumation: 10-6-1972  
 60. Date of reburial: 10-6-1972  
 61. Date of reinterment: 10-6-1972  
 62. Date of reexhumation: 10-6-1972  
 63. Date of reburial: 10-6-1972  
 64. Date of reinterment: 10-6-1972  
 65. Date of reexhumation: 10-6-1972  
 66. Date of reburial: 10-6-1972  
 67. Date of reinterment: 10-6-1972  
 68. Date of reexhumation: 10-6-1972  
 69. Date of reburial: 10-6-1972  
 70. Date of reinterment: 10-6-1972  
 71. Date of reexhumation: 10-6-1972  
 72. Date of reburial: 10-6-1972  
 73. Date of reinterment: 10-6-1972  
 74. Date of reexhumation: 10-6-1972  
 75. Date of reburial: 10-6-1972  
 76. Date of reinterment: 10-6-1972  
 77. Date of reexhumation: 10-6-1972  
 78. Date of reburial: 10-6-1972  
 79. Date of reinterment: 10-6-1972  
 80. Date of reexhumation: 10-6-1972  
 81. Date of reburial: 10-6-1972  
 82. Date of reinterment: 10-6-1972  
 83. Date of reexhumation: 10-6-1972  
 84. Date of reburial: 10-6-1972  
 85. Date of reinterment: 10-6-1972  
 86. Date of reexhumation: 10-6-1972  
 87. Date of reburial: 10-6-1972  
 88. Date of reinterment: 10-6-1972  
 89. Date of reexhumation: 10-6-1972  
 90. Date of reburial: 10-6-1972  
 91. Date of reinterment: 10-6-1972  
 92. Date of reexhumation: 10-6-1972  
 93. Date of reburial: 10-6-1972  
 94. Date of reinterment: 10-6-1972  
 95. Date of reexhumation: 10-6-1972  
 96. Date of reburial: 10-6-1972  
 97. Date of reinterment: 10-6-1972  
 98. Date of reexhumation: 10-6-1972  
 99. Date of reburial: 10-6-1972  
 100. Date of reinterment: 10-6-1972  
 101. Date of reexhumation: 10-6-1972  
 102. Date of reburial: 10-6-1972  
 103. Date of reinterment: 10-6-1972  
 104. Date of reexhumation: 10-6-1972  
 105. Date of reburial: 10-6-1972  
 106. Date of reinterment: 10-6-1972  
 107. Date of reexhumation: 10-6-1972  
 108. Date of reburial: 10-6-1972  
 109. Date of reinterment: 10-6-1972  
 110. Date of reexhumation: 10-6-1972  
 111. Date of reburial: 10-6-1972  
 112. Date of reinterment: 10-6-1972  
 113. Date of reexhumation: 10-6-1972  
 114. Date of reburial: 10-6-1972  
 115. Date of reinterment: 10-6-1972  
 116. Date of reexhumation: 10-6-1972  
 117. Date of reburial: 10-6-1972  
 118. Date of reinterment: 10-6-1972  
 119. Date of reexhumation: 10-6-1972  
 120. Date of reburial: 10-6-1972  
 121. Date of reinterment: 10-6-1972  
 122. Date of reexhumation: 10-6-1972  
 123. Date of reburial: 10-6-1972  
 124. Date of reinterment: 10-6-1972  
 125. Date of reexhumation: 10-6-1972  
 126. Date of reburial: 10-6-1972  
 127. Date of reinterment: 10-6-1972  
 128. Date of reexhumation: 10-6-1972  
 129. Date of reburial: 10-6-1972  
 130. Date of reinterment: 10-6-1972  
 131. Date of reexhumation: 10-6-1972  
 132. Date of reburial: 10-6-1972  
 133. Date of reinterment: 10-6-1972  
 134. Date of reexhumation: 10-6-1972  
 135. Date of reburial: 10-6-1972  
 136. Date of reinterment: 10-6-1972  
 137. Date of reexhumation: 10-6-1972  
 138. Date of reburial: 10-6-1972  
 139. Date of reinterment: 10-6-1972  
 140.

APR 20 1964  
BUREAU OF VITALS  
STATES  
City of  
County

CHANCE TO STATE

Form V. S. No. 5 20M.1-16-12

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH *Shoshone* Registration District No. *70*  
 County of *Shoshone* Primary Registration District No. *1911*  
 City of *Wallace* BUREAU OF VITAL STATISTICS  
 If death occurs away from usual residence, give facts called for under special information.

File No. *33578*  
 Registered No. *33578*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Infant Davis*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*  
 (Write the word.)

6. DATE OF BIRTH *Febr 19 1921*  
 (Month) (Day) (Year)

7. AGE *0* yrs. *0* mos. *0* ds. IF LESS than 1 day how many *0* hrs. or *0* mins.

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

*none*

## 9. BIRTHPLACE

(State or Country)

*Shoshone Idaho*

## 10. NAME OF FATHER

*George Davis*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Iowa*

## 12. MAIDEN NAME OF MOTHER

*Louisa Dalton*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Illinois*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*George Davis*  
*Wallace Idaho*

(Address)

## 15.

Filed *Febr 22 1921*

1921

*F. L. Lumber*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16. DATE OF DEATH

*Febr 19 1921*  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191,

that I last saw *her* alive on 191,

and that death occurred on the date stated above, at *7:45* M.

The CAUSE OF DEATH\* was as follows:

*Still born*

(Duration) yrs. mos. ds.

Contributory  
 (Secondary)

*none*

(Duration) yrs. mos. ds.

(Signed)

*Dr. M. W. G. M. D.*  
*Feb 21 1921* (Address) *Wallace*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

*none*

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Wallace Ida* *Feb. 22 1921*

## 20. UNDERTAKER

ADDRESS

*Harry Thompson* *Wallace*  
*Idaho*

18912

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Street-carry fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill;* (a) *Salesman, (b) Grocery;* (a) *Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

459-217-040-624

PLACE OF BIRTH

RECEIVED

APR 5 1921

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

County of ShoshoneBUREAU OF VITAL STATISTICS  
ARTIFICATE OF BIRTH

S 88881

City of BurkeRegistration District No. 70File No. 83355

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 144Registered No. 44

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Miss Merlino (Still Born)

Sex of Child

7Twin  
Triplet  
or other?and { Number  
in order  
of birthLegiti  
mate?ye

Date of Birth

3171921

(Month)

(Day)

(Year)

FULL NAME

FATHER

Nicholas Merlino

RESIDENCE

Burke

COLOR

WAGE AT LAST  
BIRTHDAY24  
(Years)

BIRTHPLACE

Italy

OCCUPATION

MinerFULL  
MAIDEN  
NAME

MOTHER

Margaret Osmund

RESIDENCE

Burke

COLOR

WAGE AT LAST  
BIRTHDAY19  
(Years)

BIRTHPLACE

Burke

OCCUPATION

HousewifeNumber of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Still born, at 2 P. M.  
on the date above stated. (Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Dr. Chas. W. Dutton

(Physician or midwife)

Given names added from a supplemental report.

19

Address

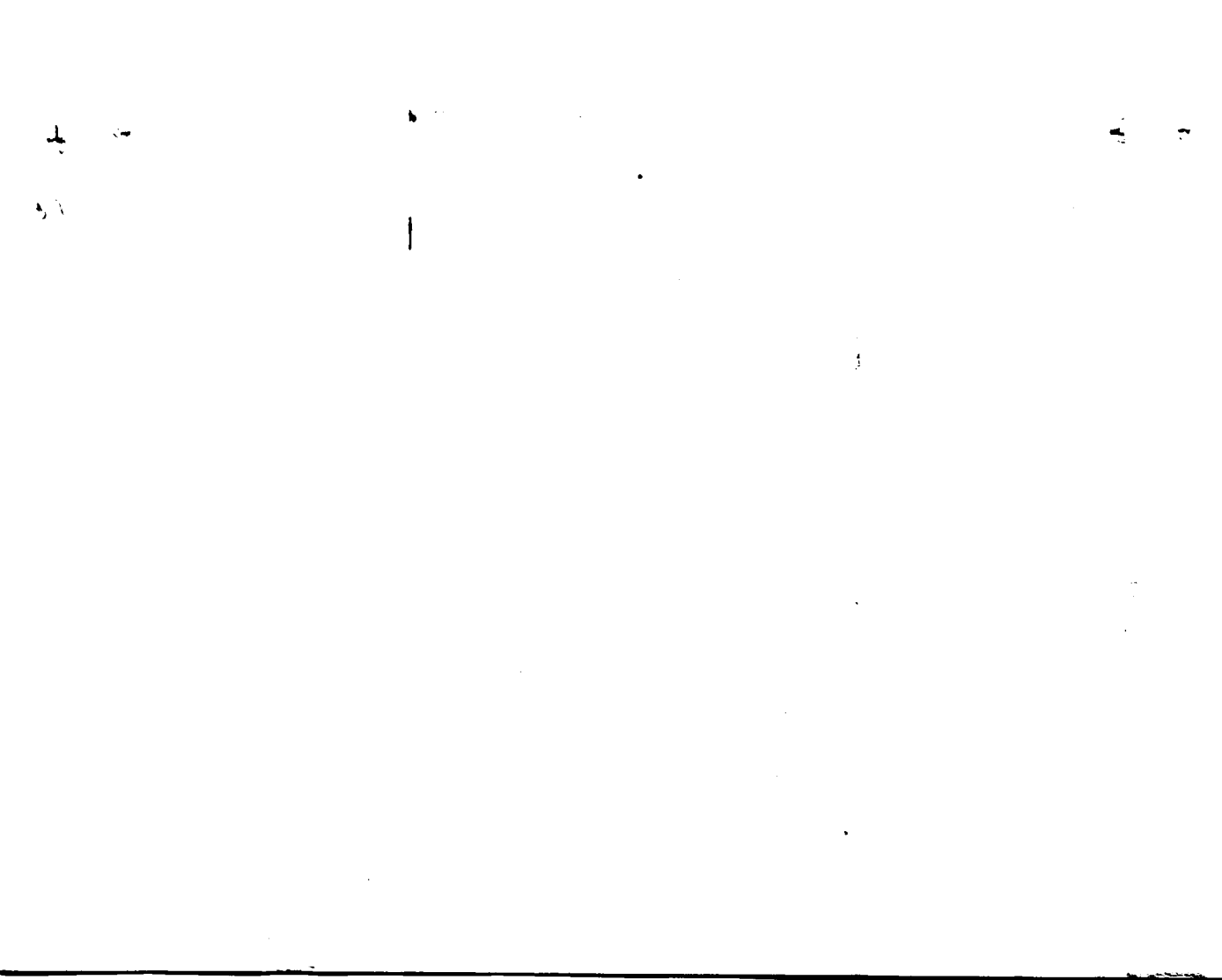
1500 Idaho

Date

Mar 30 1921

Registrar

Registrar





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED

## CERTIFICATE OF DEATH

 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

 1. PLACE OF DEATH. **APR 5 1921** Registration District No. 70  
 County of Shoshone Registration District No. 1001  
 City of Burke (St.)
File No. 33583Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Miss Werline (Steele)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

 3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single  
 (Write the word.)

 6. DATE OF BIRTH March 17 1921  
 (Month) (Day) (Year)

 7. AGE Born dead IF LESS than 1 day  
 how many.....hrs. or  
 ....min?

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work.
- 
- (b) General nature of industry business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Burke

## 10. NAME OF FATHER

Nicholas Werline

## 11. BIRTHPLACE OF FATHER

(State or Country)

Italy

## 12. MAIDEN NAME OF MOTHER

Margaret Osmund

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Burke Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

 15. Mar 17 1921 P L Jones  
 Filed Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

## 16. DATE OF DEATH

March 17 1921  
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from 191, to 191

 that I last saw him alive on 191

 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

(Duration) .....yrs. ....mos. ....ds.

 Contributory  
 (Secondary)

(Duration) .....yrs. ....mos. ....ds.

 (Signed) Chas. C. Dethman M. D.  
March 17 1921 (Address) Burke Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

 At place In the  
 of death.....yrs. ....mos. ....ds. State.....yrs. ....mos. ....ds.

 Where was disease contracted,  
 If not at place of death?

 Former or  
 usual residence.

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

BurkeMarch 17 1921

## 20. UNDERTAKER

Father

## ADDRESS

Burke Idaho

18913

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

965-203-042-691

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Twin Falls

APR 9 1921

CERTIFICATE OF BIRTH

S 88925

City of Buhl

BUREAU OF VITAL

STATISTICS

Registration District No. 39

File No. 22889

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2087

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Sex of Child <u>female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legit mate? <u>yes</u>	Date of Birth <u>9</u> <u>9</u> <u>1921</u> (Month) (Day) (Year)
----------------------------	------------------------------	-----------	--------------------------------	------------------------	---

FATHER  
FULL NAME H. A. Rodrig

MOTHER  
FULL MAIDEN NAME Minnie Franklin

RESIDENCE Buhl

RESIDENCE Buhl

COLOR white AGE AT LAST BIRTHDAY 26  
(Years)

COLOR white AGE AT LAST BIRTHDAY 19  
(Years)

BIRTHPLACE California

BIRTHPLACE Colo.

OCCUPATION Farmer

OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:30 P.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]  
(Physician or midwife)

Given names added from a supplemental report. \_\_\_\_\_  
19 \_\_\_\_\_

Address Buhl Idaho  
File APR 1 1921 19 \_\_\_\_\_  
Registrar J. T. Murphy

Registrar

RECEIVED BY THE BUREAU OF THE DISTRICT ATTORNEY

RECEIVED BY THE BUREAU OF THE DISTRICT ATTORNEY

2 88882

BUREAU OF THE DISTRICT ATTORNEY

Primary Registration District No. 1001

Primary Registration District No. 1001

Child's Name

CHILD'S NAME OF CHILD

Sex

Age

Weight

Height

Date of Birth

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

Color

Place of Birth

Parents' Names

Parents' Names

Parents' Names

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

## RECEIVED CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Twin Falls*  
City of *Buhl*

Registration District No.

Primary Registration District No. *2087*  
(No. *39* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. *33611*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Female*

4. COLOR OR RACE

*white*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

*3* *3* *1921*  
(Month) (Day) (Year)

7. AGE

.....yrs.....mos.....ds.

IF LESS than 1 day  
how many .....hrs. or  
.....mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Buhl Ida.*

10. NAME OF FATHER

*H. A. Rodig*

11. BIRTHPLACE OF FATHER

(State or Country)

*Calif*

12. MAIDEN NAME OF MOTHER

*Minnie Franklin*

13. BIRTHPLACE OF MOTHER

(State or Country)

*colo*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*H. A. Rodig*  
*Buhl Ida.*

(Address)

15.

Filed *3-4**1921*

*J. H. Murphy*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

*3* *3* *1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....191....., to .....191.....,

that I last saw *h.* alive on .....191.....,and that death occurred on the date stated above, at *2* M.

The CAUSE OF DEATH\* was as follows:

*Accident of delivery*  
*Transverse presentation*  
*in pump-handle position*  
*Delay of birth of*  
*extra large head*  
(Duration) .....yrs.....mos.....ds.  
Contributory  
(Secondary) *extra large head*  
(Duration) .....yrs.....mos.....ds.

(Signed)

*J. H. Murphy* M. D.  
*3/4/21* (Address) *Buhl Ida.*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

*Own ranch*

DATE OF BURIAL

*3/4/21*

20. UNDERTAKER

*Home Collection*

ADDRESS

*T*

1522

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

356-104-042-993

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

88988

S

County of Twin Falls

City of Twin Falls Ida.

Registration District No. 35

File No. 33462

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 185

Registered No. \_\_\_\_\_

Hospital County

FULL NAME OF CHILD Infant Lewis.

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate?	Date of Birth <u>Feb. 4-3 1921</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-----------------	--

FULL NAME FATHER Hervey Lewis

RESIDENCE Twin Falls Idaho

COLOR White AGE AT LAST BIRTHDAY 34  
(Years)

BIRTHPLACE Washington (Goldendale?)

OCCUPATION Mechanical Engineer

FULL MAIDEN NAME MOTHER Alberta Richardson

RESIDENCE Twin Falls Idaho

COLOR White AGE AT LAST BIRTHDAY 19  
(Years)

BIRTHPLACE Hochmeil Colorado

OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Stillborn, at 11:30 P.M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. M. Vanler  
(Physician or midwife)

Given names added from a supplemental report.

Address Twin Falls  
Filed Feb. 12 1921 J. T. Loughlin  
Registrar

[illegible]

STATE OF TEXAS  
COUNTY OF DALLAS  
CERTIFICATE OF BIRTH

Registered No. 1011

blind)

RESIDENCE

444

the staff  
dining

BIRTHPLACE

TEAM TA BOA  
YADOTTLE

33A194T018

\_\_\_\_\_

(continued)

**THE**



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

165-130-001-243

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

MAY 7 1921

CERTIFICATE OF BIRTH

County of Ada

BUREAU OF VITAL

City of Boise

STATISTICS

Registration District No. 2

File No. 89049

No. 613 1/2 S. 13 St.

Primary Registration District No. 1004

Registered No. 171

Hospital -

FULL NAME OF CHILD

Jones

Sex of Child Male

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and  
Number  
in order  
of birth

Legiti  
mate? l

Date of Birth Mar 30 19 21  
(Month) (Day) (Year)

FULL NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY 36  
(Years)

BIRTHPLACE

OCCUPATION

FULL MAIDEN NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY 34  
(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still born, at 1119 M.  
on the date above stated. (Born ~~alive~~ stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

D. O. N. Parker

(Physician or midwife)

Given names added from a supplemental report.

19

Address

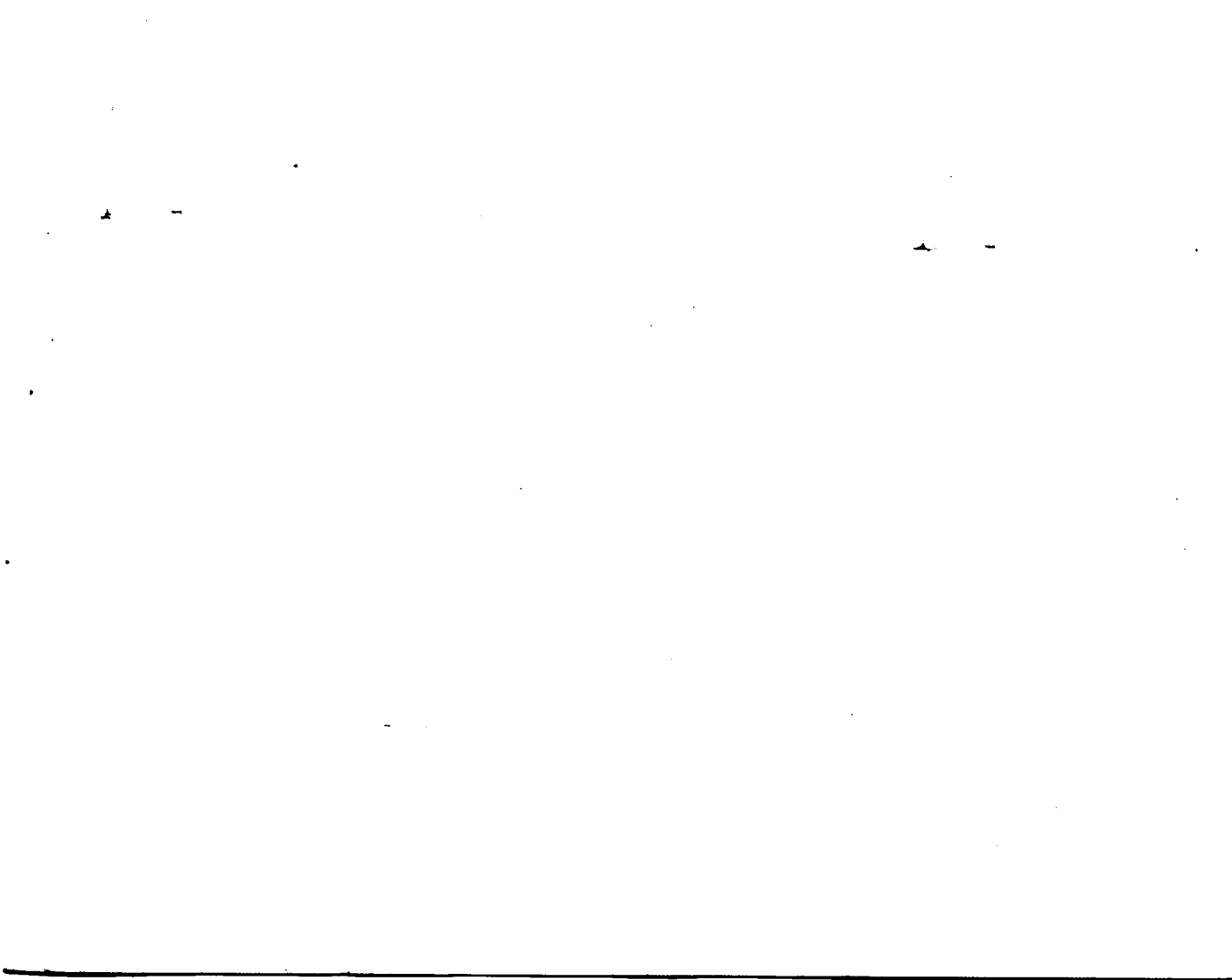
Filed

19 21

Registrar

Registrar

R. N. Pad



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. **33267**  
Registered No. **95-**

## 1. PLACE OF DEATH

County of Ada  
City of Boise  
Registration District No. 13th  
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
APR 7 1921  
BUREAU OF VITAL STATISTICS

## 2. FULL NAME

Baby Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Mar. 28 1921

(Month) (Day) (Year)

## 7. AGE

— Yrs. — Mos. — ds.(IF LESS than 1 day  
how many hrs.  
or min.?)

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)Still Born

## 9. BIRTHPLACE

(State or Country)

Boise, Idaho

## 10. NAME OF FATHER

J. H. Jones

## 11. BIRTHPLACE OF FATHER

(State or Country)

Mo

## 12. MAIDEN NAME OF MOTHER

Rosa Butler

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Bliss, Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. C. Brabney

(Address)

Boise Idaho

## 15.

Filed

Mar 28 1921R. H. Prater

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Mar. 28 1921

(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Mar 25 1921, at birththat I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Prater

M. D.

3/28/21 (Address) Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Star Cemetery

## DATE OF BURIAL

3/29 1921

## 20. UNDERTAKER

W. H. Prater

## ADDRESS

Boise Idaho

18912

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

993-125-003-689

## PLACE OF BIRTH

County of BenewahCity of LocateNo. 1Hospital Roosevelt GeneralFULL NAME OF CHILD Stillborn

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

RECEIVED

MAY 9 - 1921

CERTIFICATE OF BIRTH

Form V. S. No. 11-C--25m-7-21-19

S 89146

File No. 71

BUREAU OF VITAL STATISTICS

Registration District No. 28Primary Registration District No. 2161Registered No. 3753Sex of Child MTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate? yesDate of  
Birth 4 25 1921

(Month)

(Day)

(Year)

FULL  
NAME

FATHER

RESIDENCE

COLOR W.AGE AT LAST  
BIRTHDAY 26

(Years)

BIRTHPLACE

OCCUPATION TeacherFULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

COLOR W.AGE AT LAST  
BIRTHDAY 24

(Years)

BIRTHPLACE

OCCUPATION HousewifeNumber of child of this mother, including present birth 1Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was dead at 10<sup>30</sup> P. M. on the date above stated.

(Dead—live or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]

(Physician or midwife)

Given names added from a supplemental report.

19

Address PocatelloFiled 5/1 1921

Registrar

Registrar [Signature]

only the subject of trial in order to find out whether or not there was any other person who was in the room at the time of the murder.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Bannock*City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No. *28*Primary Registration District No. *2161*

BUREAU OF VITAL STATISTICS

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *40 33689*Registered No. *3568*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

*Whitney Rich*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*white*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Infant*  
(Write the word.)

## 6. DATE OF BIRTH

*April 25 1921*  
(Month) (Day) (Year)

## 7. AGE

*Stillborn*

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

*Infant*

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

*Pocatello Ida.*

## 10. NAME OF FATHER

*L. S. Rich*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Pavia Ida.*

## 12. MAIDEN NAME OF MOTHER

*Theda Maude Whitney*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Mendon Utah*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*L. S. Rich*

(Address)

*Tyler*

## 15.

Filed

*4/27 21*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*April 25 1921*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*Stillborn* to *Stillborn*  
that I last saw him *live on* *Stillborn* *born at* *10 P. M.*  
and that death occurred on the date stated above, at *10 P. M.*

The CAUSE OF DEATH\* was as follows:

*Prematurity-*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

*4/27 21* (Address) *Pocatello* M. D.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Mountain View Bur.*

## DATE OF BURIAL

*April 27 1921*

## 20. UNDERTAKER

*Schumacher & Hall*

## ADDRESS

*Pocatello*

151 a

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



365-101-006 - 393

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of

Bingham

APR 20

CERTIFICATE OF BIRTH

S 89171

City of

Aberdeen

BUREAU OF VITAL

STATISTICS

Registration District No.

File No.

No.

St.

Primary Registration District No.

Registered No.

Hospital

FULL NAME OF CHILD

Still born Toews

Sex of  
Child

Male

Twin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate?

Yes

Date of  
Birth

Mch 1 21

(Month) (Day) (Year)

FULL  
NAMEFATHER  
John Edward ToewsFULL  
MAIDEN  
NAMEMOTHER  
Ellie M. Lichtenheld

RESIDENCE

Aberdeen Ida

RESIDENCE

Aberdeen Ida

COLOR

White

AGE AT LAST

32  
BIRTHDAY  
(Years)

COLOR

White

AGE AT LAST

38  
BIRTHDAY  
(Years)

BIRTHPLACE

Kansas

BIRTHPLACE

Iowa

OCCUPATION

Merchant

OCCUPATION

Housewife

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Still born, at 6:45 A. M.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

M. C. Markham, M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Aberdeen Ida

Filed

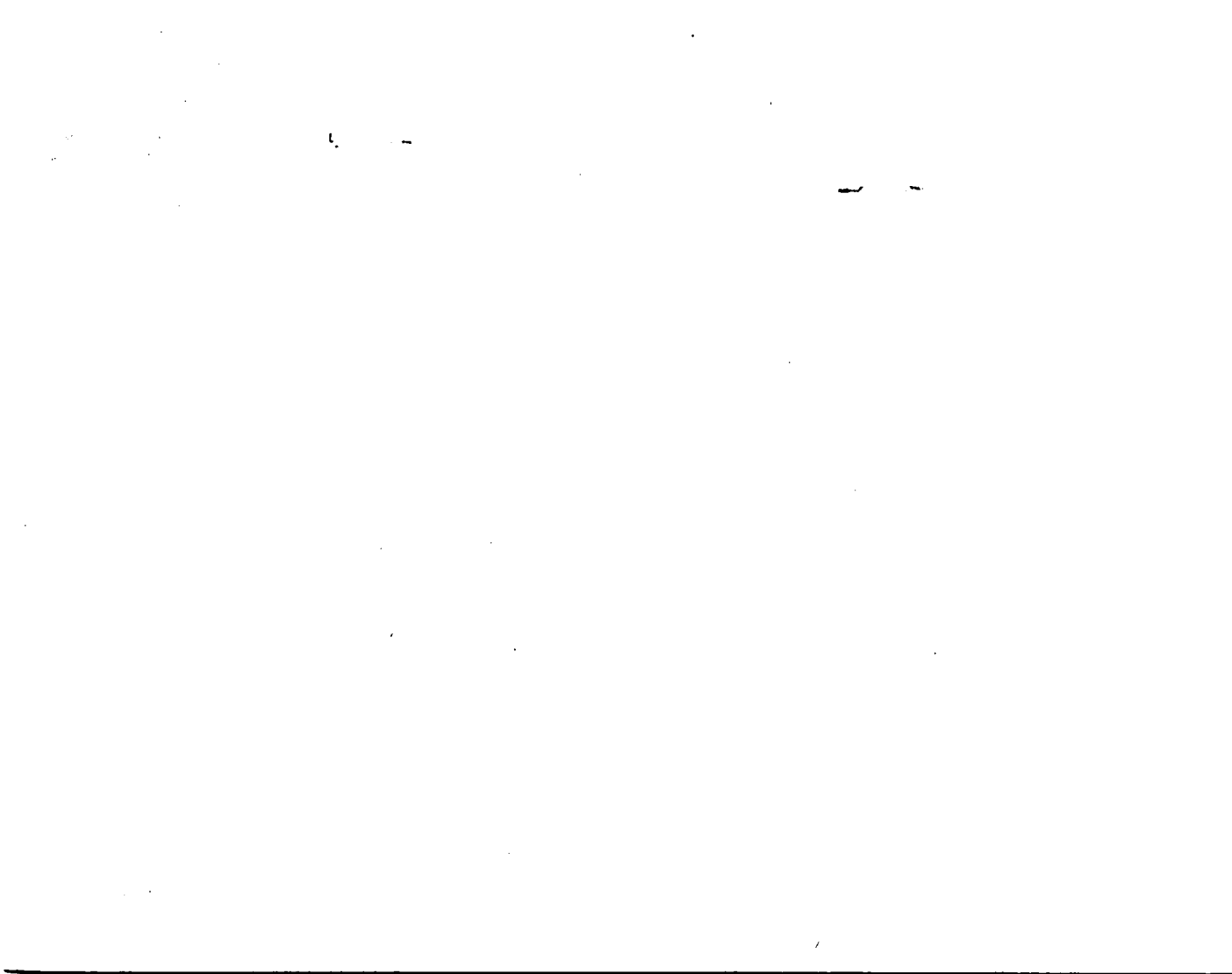
3-1-21 M. C. Markham

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WHITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.



## 1. PLACE OF DEATH

County of Bingham  
City of Aberdeen

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## RECEIVED CERTIFICATE OF DEATH

Registration District No. 116  
Primary Registration District No. 2193  
BUREAU OF VITAL STATISTICSState of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 33726  
Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE MARRIED, WID-OWED OR DIVORCED. Single  
(Write the word.)

6. DATE OF BIRTH

March 1 1921  
(Month) (Day) (Year)

7. AGE

\_\_\_\_ Yrs. \_\_\_\_ Mos. \_\_\_\_ ds.  
IF LESS than 1 day  
how many \_\_\_\_ hrs. or \_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Edward Toews

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Nellie M. Lichtenheld

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. E. Toews  
Aberdeen Ida

15.

Filed

March 1 1921 M. C. Mackinnon  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 1 1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 191\_\_\_\_ to \_\_\_\_\_ 191\_\_\_\_,  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 191\_\_\_\_,  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still born -  
Pro lapse of umbilical cord

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) M. C. Mackinnon M. D.1921 (Address) Aberdeen Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ days In the State \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Memorial Cemetery 3/3 1921  
Aberdeen Ida

20. UNDERTAKER

ADDRESS

Friends

189 B

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

815-117-006-133  
PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of CinghamRECEIVED  
APR 21 1921

CERTIFICATE OF BIRTH

City of BlackfootBUREAU OF VITAL  
STATISTICS  
Registration District No. 121File No. S-89189No. R A 75 St.Primary Registration District No. 2194 Registered No. 97

Hospital \_\_\_\_\_

FULL NAME OF CHILD Hansen

Sex of Child <u>Male</u>	Twins or other? <u>Single</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>Mar 17 1921</u> (Month) (Day) (Year)
--------------------------	-------------------------------	-----	-----------------------------------	------------------------	--

FULL NAME FATHER James Peter HansenRESIDENCE BlackfootCOLOR White AGE AT LAST BIRTHDAY 43  
(Years)BIRTHPLACE DenmarkOCCUPATION FarmingFULL MAIDEN NAME MOTHER Alta Matilda AllredRESIDENCE BlackfootCOLOR White AGE AT LAST BIRTHDAY 40  
(Years)BIRTHPLACE UtahOCCUPATION HousewifeNumber of child of this mother, including present birth 9 Number of children of this mother now living, including present birth 7

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 2:30 P. M.  
on the date above stated. (Born alive or stillborn)(Signature) W. W. Beck

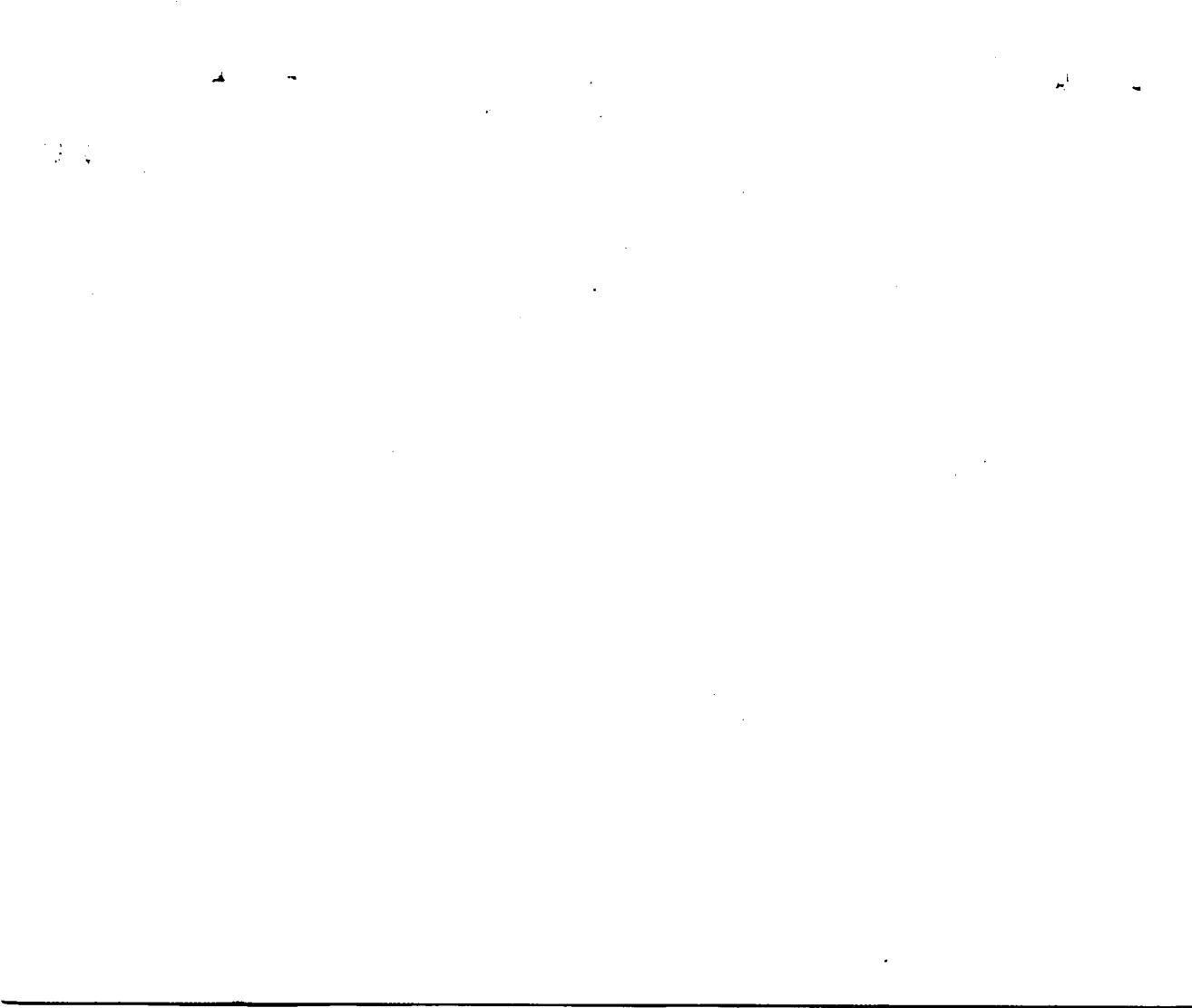
(Physician or midwife)

Address Blackfoot, IdahoFiled April 17 1921 Mrs Helen E. Patrick

Registrar

Registrar

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
33733

## 1. PLACE OF DEATH

County of Bingham  
City of Blackfoot

Registration District No. ....

Primary Registration District No. ....

(No. Between Rivers St.)

File No. ....

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

No name Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male White

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

March 17 1921  
(Month) (Day) (Year)

## 7. AGE

Sticeborn  
Yrs. Mos. ds.

IF LESS than 1 day

how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

James P. Hansen

## 11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

## 12. MAIDEN NAME OF MOTHER

Alta Matilda Alford

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James P. Hansen

(Address)

Blackfoot, Ida

## 15.

Filed

19

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sticeborn Mar 17 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....  
that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Sticeborn Had  
probably been dead about 10 days  
(Duration) Yrs. mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. W. Beck M. D.3/17/21 (Address) Blackfoot, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Grove City CemeteryMar 19 1921

## 20. UNDERTAKER

## ADDRESS

Ed L. EgleBlackfoot

189 B

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

295-130-006-276

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Bingham

APR 21 1921

CERTIFICATE OF BIRTH

City of Blackfoot

BUREAU OF VITAL

STATISTICS

File No. S 89205No. 121 St. 2194Primary Registration District No. 2194Registered No. 113Hospital ✓FULL NAME OF CHILD Stiel Birth BuggenkampSex of  
ChildMaleTwin  
Triplet  
or other?  
(To be answered only in event of plural births)

{ and {

Number  
in order  
of birth  
5Legiti  
mate?YesDate of  
BirthMar 30 - 19 21  
(Month) (Day) (Year)FULL  
NAMEFATHER  
Henry Buggenkamp

RESIDENCE

N. East Blackfoot

COLOR

WhiteAGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

Idaho

OCCUPATION

FarmerFULL  
MAIDEN  
NAMEMOTHER  
Mary Spornbauer

RESIDENCE

N. E. Blackfoot

COLOR

WhiteAGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

Idaho

OCCUPATION

HousewifeNumber of child of this mother, including present birth, 5Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stielborn,  
on the date above stated.

(Born alive or stillborn)

at 29. M.

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

A. J. Simmons

(Physician or midwife)

Given names added from a supplemental report.

19

Address

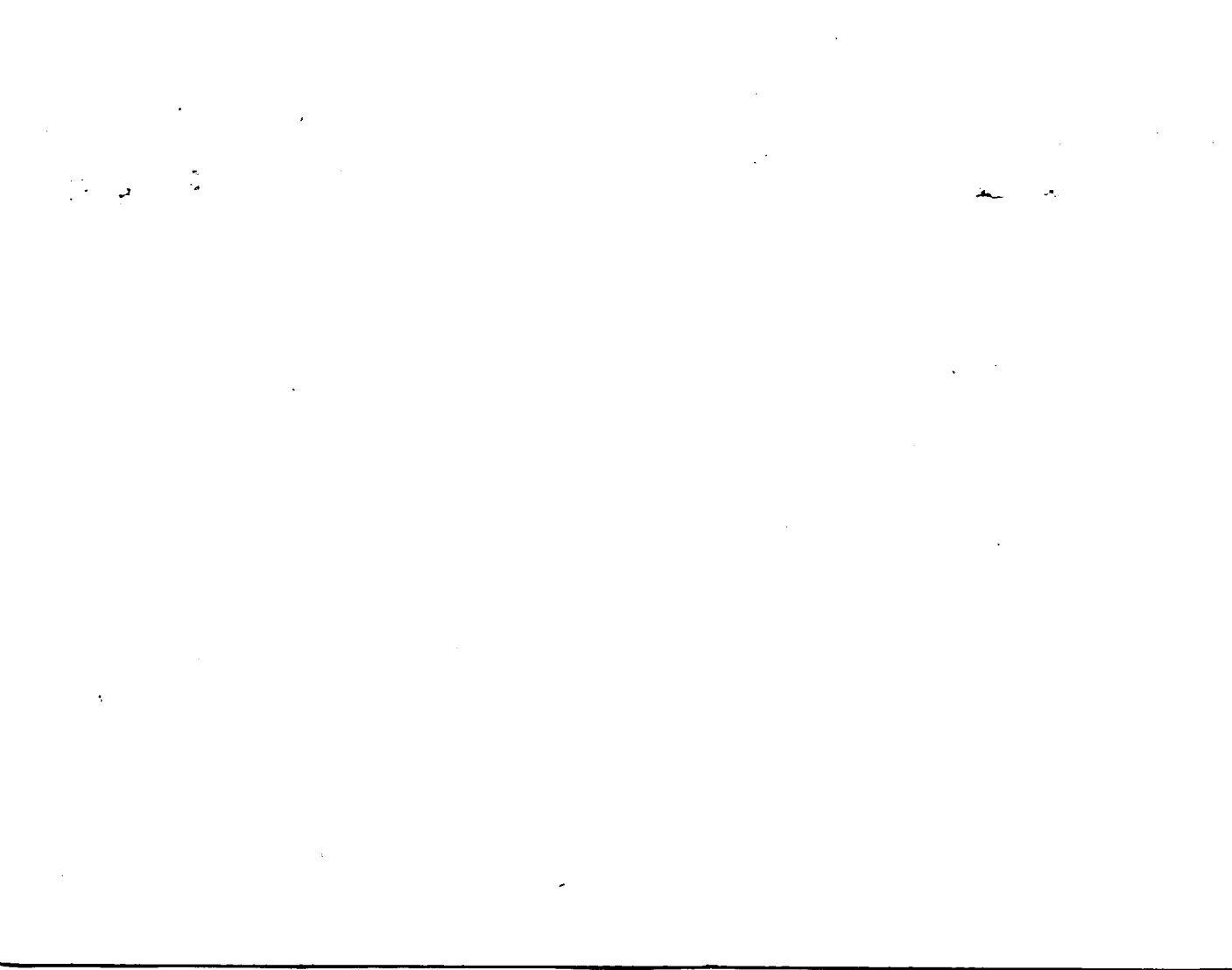
Blackfoot Idaho

Filed

Apr. 17 1921 Mrs. Hattie E. Patrick

Registrar

Registrar



RECEIVED

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Bingham Registration District No. 1  
 City of Blackfoot Registration District No. 3 St. Idaho

If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

## 2. FULL NAME

"Still Birth"File No. 33743Registered No. 48

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

march - 28 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. ✓ Mos. ✓ ds. ✓ IF LESS than 1 day  
how many... hrs. or... min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work. none  
(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

Henry Buggenbump

## 11. BIRTHPLACE OF FATHER

(State or Country) Iowa

## 12. MAIDEN NAME OF MOTHER

Mary Spanbauer

## 13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Buggenbump  
(Address) Blackfoot Idaho

## 15.

Filed 19 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

march 28 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

march 28 1921, to march 28 1921that I last saw him alive on march 28 1921

and that death occurred on the date stated above, at... M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory (Secondary) Premature

(Duration) yrs. mos. ds.

(Signed) H. J. Linn M. D.3/29/21 (Address) Blackfoot Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted  
if not at place of death?

Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Funeral Home

## DATE OF BURIAL

3-29-21

## 20. UNDERTAKER

E. J. Smith

## ADDRESS

Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1898

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

168-225-00-856

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

RECEIVED STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
APR 21 1921

County of BonnevilleCity of Idaho Falls

BUREAU OF VITAL

Register District No. 73

File No.

S 89238

No. \_\_\_\_\_ St.

Primary Registration District No. 2117Registered No. 710

Hospital \_\_\_\_\_

## FULL NAME OF CHILD

Sex of Child Female { Twin Triplet or other? } and { Number in order of birth } Legiti mate? yes Date of Birth Feb 25 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Oscar Johnson  
RESIDENCE Idaho Falls, Idaho  
COLOR White AGE AT LAST BIRTHDAY 34 (Years)  
BIRTHPLACE Elkhart Indiana  
OCCUPATION Carpenter

MOTHER  
FULL MAIDEN NAME Esther Hewlin  
RESIDENCE Idaho Falls Idaho  
COLOR White AGE AT LAST BIRTHDAY 31 (Years)  
BIRTHPLACE Chicago, Illinois  
OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Premature 5 1/2 mo., at 4:30 P.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

A. P. Soderstrom  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Idaho Falls Idaho

Filed

Mar 7 19 21 Unpublished

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

Ad

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

855-112.021-133

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of Franklin

MAY 7 1921

CERTIFICATE OF BIRTH

City of Roosevelt

BUREAU OF VITAL

Registration District No. 2119

File No. 89427

No. \_\_\_\_\_ St.

Primary Registration District No. 27

Registered No. 99

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Stillborn

Sex of Child M

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and

Number  
in order  
of birth  
(To be answered only in event of plural births)

Legiti  
mate?

Date of  
Birth

April 12 1921  
(Month) (Day) (Year)

FULL  
NAME

FATHER

William Jacob Hensler

FULL  
MAIDEN  
NAME

MOTHER

Ma May Allen

RESIDENCE

Roosevelt Idaho

RESIDENCE

Roosevelt Idaho

COLOR

W

AGE AT LAST  
BIRTHDAY

3  
(Years)

COLOR

W

AGE AT LAST  
BIRTHDAY

1  
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Utah

OCCUPATION

Farming

OCCUPATION

Housewife

Number of child of this mother, including present birth 11

Number of children of this mother now living, including present birth 8

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn  
on the date above stated.

(Born alive or stillborn)

at 7 a M.

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

Curtis Hand  
Physician

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Preston Idaho

Filed

May 4

1921

Dr. H. C. Curtis

Registrar

Registrar

MARYIA RESERVED FOR BINDING

THIS IS A PRELIMINARY REPORT  
 WHILE PENDING THE CASE IS A PRELIMINARY REPORT  
 DO NOT BE USED FOR ANY OTHER PURPOSE  
 DO NOT BE USED FOR ANY OTHER PURPOSE

STATE OF IDAHO  
 BUREAU OF VITAL STATISTICS  
 MAY 7 CERTIFICATE OF BIRTH

County of Blaine  
 City of Blaine  
 Registered No. 2  
 Prime Registration District No. 2  
 Registered No. 2

CHILD'S NAME OF CHILD  
 Sex of Child Male  
 Date of Birth May 7 1918  
 Time of Birth 10:30  
 Place of Birth Blaine  
 Name of Father John J. Blaine  
 Name of Mother John J. Blaine  
 Residence of Father Blaine  
 Residence of Mother Blaine  
 Color of Child White  
 Age at Last Birthday 1  
 Birthplace Idaho  
 Occupation None

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  
 I hereby certify that I attended the birth of this child, who was  
 (Born alive or stillborn)  
 (Signature)  
 (Physician or midwife)  
 Address Blaine  
 Filed May 7 1918  
 Registrar John J. Blaine



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
33820  
File No. \_\_\_\_\_  
Registered No. 26

## 1. PLACE OF DEATH

County of Franklin District No. 2119  
City of Rosevelt District No. 27 St.)

If death occurs away from usual residence, give facts called for under special information.

## BUREAU OF VITAL STATISTICS

## 2. FULL NAME

Stillborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M W Single  
(Write the word.)

## 6. DATE OF BIRTH

April 12 1921  
(Month) (Day) (Year)

## 7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
how many 0 hrs.  
or 0 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

None

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

William Jacob Neusser

## 11. BIRTHPLACE OF FATHER

(State or Country)

Utah

## 12. MAIDEN NAME OF MOTHER

Ida May Allen

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm J. Neusser  
Preston, Idaho

## 15.

Filed May 5 1921, D. A. Culter  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

April 12 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1921, to April 12 1921, that I last saw him alive on April 12 1921, and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn — due to partial abruption placentae

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory (Secondary)

unknown

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

Curtis Blank

M. D.

4-12-21 (Address) Preston, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Rosevelt Idaho 4-12-1921

## 20. UNDERTAKER

## ADDRESS

None

18912

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

553.130-023 455

PLACE OF BIRTH

RECEIVED

APR 16 1921

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of 2em

BUREAU OF VITAL

CERTIFICATE OF BIRTH

City of Emmett

STATISTICS

Registration District No. \_\_\_\_\_

File No. S 89453

No. \_\_\_\_\_

St. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD Melvin A. NelsonSex of Child MaleTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate?yesDate of Birth Mar 30 1921

(Month)

(Day)

(Year)

FULL NAME FATHER Chas Adrian NelsonRESIDENCE Emmett IdahoCOLOR WhiteAGE AT LAST BIRTHDAY 22

(Years)

BIRTHPLACE Salem IdahoOCCUPATION Lumber pilerFULL MAIDEN NAME MOTHER Naomi A. BentonRESIDENCE Emmett IdaCOLOR whiteAGE AT LAST BIRTHDAY 24

(Years)

BIRTHPLACE Ureca ColoOCCUPATION H. wifeNumber of child of this mother, including present birth 1Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 4:20 a M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) R. J. Cummings

(Physician or midwife)

Given names added from a supplemental report.

19

Address EmmettFiled 4/14 1920

Registrar

Registrar J. H. Reynolds



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

593-122 1028-815

PLACE OF BIRTH

RECEIVED

MAY 10 1921

Form V. S. No. 11-C-28m-7-21-19

County of Gooding

City of Gooding

BUREAU OF VITAL STATISTICS

STATISTICS

Registration District No. 24

File No.

S 89475

No.

St.

Primary Registration District No.

Registered No.

FULL NAME OF CHILD

George Andrew Nichols

Sex of Child

boy

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and  
Number  
in order  
of birth

Legiti  
mate?

yes.

Date of Birth

April 29 1921  
(Month) (Day) (Year)

FULL NAME

FATHER

Harry Nichols

FULL  
M.A.DEN  
NAME

MOTHER

Violet L. Laurensen

RESIDENCE

Gooding, Idaho

RESIDENCE

Gooding

COLOR

white

AGE AT LAST  
BIRTHDAY

34  
(Years)

COLOR

white

AGE AT LAST  
BIRTHDAY

34  
(Years)

BIRTHPLACE

Indiana

BIRTHPLACE

Oregon

OCCUPATION

Farmer

OCCUPATION

Housewife

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 6 mo. at 8:00 on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. W. C. Lauck

(Physician or midwife)

per M. T. Bailey

Given names added from a supplemental report.

19

Address

Gooding, Idaho

Filed

5-4-1921

77 Canyon

Registrar

Registrar

20TH

TO THE ADMIRAL

3Y-90

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

RECEIVED  
JUN 30  
BUREAU OF  
STATISTICS

Idaho,.....JUN...7.1921.....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place { City *Gooding* ..... File Number *898701* .....  
of { Street .....  
Birth { County *Gooding* ..... Registration Dist. No. *24* .....  
Sex of Child *male* ..... Date of Birth *April 22* 1921 .....  
Father *Harry Andrew Nichols* ..... Mother *Viola Jane Hanson* .....  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*George Andrew Nichols* .....  
Child's Name in Full  
*Mr. V. Jane Nichols* .....  
Signature of Father or Mother





MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

619-001-02K-813

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of Gooding

RECEIVED

CERTIFICATE OF BIRTH

City of Gooding

MAY 10 1921

S-89481

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 24

File No. \_\_\_\_\_

BUREAU OF VITAL STATISTICS

Hospital \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Harrington

Sex of Child

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti  
mate?

Date of  
Birth

Apr. 1 1921  
(Month) (Day) (Year)

(To be answered only in event of plural births)

FULL  
NAME

FATHER.

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth 8 Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was premature (ma. stillborn) M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

H. C. Lamb  
per W. T. Bailey  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Gooding, Idaho -

Filed 5-4-21 1921

J. J. Canyon

Registrar

Registrar

am

769-207024-268

PLACE OF BIRTH

County of

City of

No.

St.

Hospital

FULL NAME OF CHILD

Sex of Child

Twin  
Triplet  
or other?and  
Number  
in order  
of birthLegiti  
mate?Date of  
Birth

1921

FULL  
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Given names added from a supplemental report.

19

Address

Filed

19

Registrar

(Physician or midwife)

Registrar

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

APR 14 1921

BUREAU OF VITAL

Register

File No.

S 89492

Primary Registration District No.

Registered No.

Female

Twin  
Triplet  
or other?and  
Number  
in order  
of birthLegiti  
mate?Date of  
Birth

1921

FULL  
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Given names added from a supplemental report.

19

Address

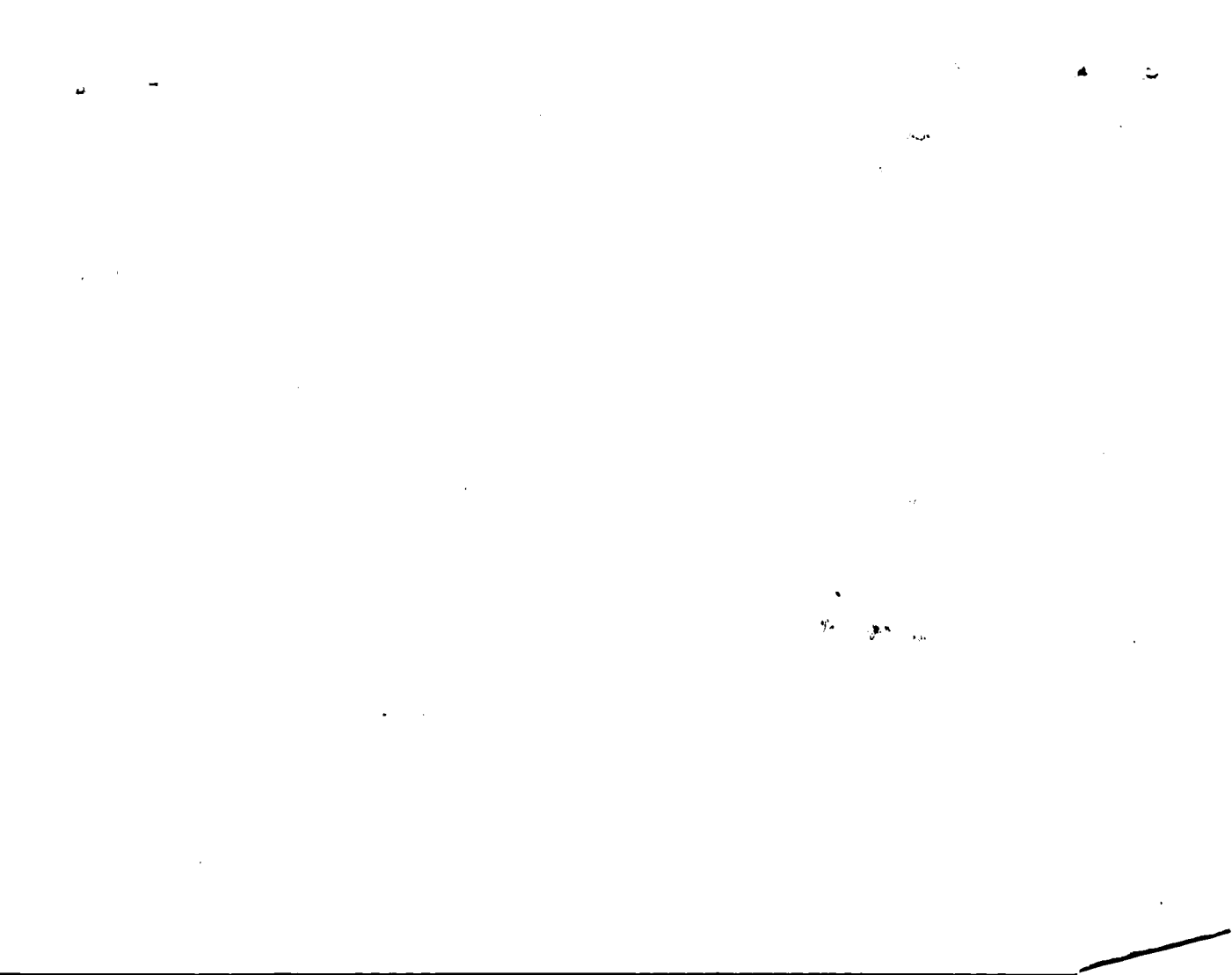
Filed

19

Registrar

(Physician or midwife)

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## RECEIVED CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

Gooding  
County of Hagerman  
City of Hagerman

Registration District No. 24

APR 14 1921

Primary Registration District No.

BUREAU OF VITAL STATISTICS

File No. 33852

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Edwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Baby  
(Write the word.)

6. DATE OF BIRTH.

March 7 1921  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ray Edwin

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lufey Boyer

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Samuel R. Gorin

(Address)

Hagerman, Ida.

15.

Filed

3-7-1921

F J Layman

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 7 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Child stillborn  
premature

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) H. O. Lumb M. D.

3/7 1921 (Address) Gooding

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death...yrs...mos...days In the State...yrs...mos...days

Where was disease contracted if not at place of death?...

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hagerman Ida

DATE OF BURIAL

3-7-1921

20. UNDERTAKER

A E Thompson

ADDRESS

Gooding Ida

18972

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

819-131-025-964

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of IdahoRECEIVED  
CERTIFICATE OF BIRTHCity of Grangeville

MAY 10 1921

BUREAU OF VITAL No. 103File No. S 89507

No. \_\_\_\_\_ St. \_\_\_\_\_

## STATISTICS

Hospital \_\_\_\_\_

Primary Registration District No. 2181 Registered No. 24

## FULL NAME OF CHILD

Stillborn

Sex of Child

MaleTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate?yesDate of  
BirthMarch 311921FULL  
NAMEFATHER Joseph Bryant HazelbakerFULL  
MAIDEN  
NAMEMOTHER Margarita Rode

RESIDENCE

Grangeville

RESIDENCE

Grangeville

COLOR

whiteAGE AT LAST  
BIRTHDAY35  
(Years)

COLOR

whiteAGE AT LAST  
BIRTHDAY25  
(Years)

BIRTHPLACE

Custer Co. Nebr

BIRTHPLACE

Merced Co. Calif.

OCCUPATION

Farmer

OCCUPATION

HousewifeNumber of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at S. P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

B Chipman  
Physician

(Physician or midwife)

Given names added from a supplemental report.

19.

Address

Grangeville, Idaho

Filed

May 1 1921 G. S. Stricklin

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
DIVISION OF BIRTH RECORDS  
BOSTON, MASSACHUSETTS

STATE OF MASSACHUSETTS

BUREAU OF VITAL STATISTICS  
DIVISION OF BIRTH RECORDS  
BOSTON, MASSACHUSETTS

RECEIVED  
MAY 10 1921

STATIONER  
BOSTON, MASSACHUSETTS

File No.

Primary Registration District No. 1181 Registered No. 1181

FULL NAME OF CHILD

Sex of Child

(To be answered only in event of plural births)

Left

Right

MOTHER

FATHER

RESIDENCE

RESIDENCE

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

BIRTHDAY

BIRTHDAY

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

(Born alive or stillborn)

When there was no attending physician or midwife, the father, mother, or other person should make this report. A stillborn child is one that is born dead, or one that is born alive but dies within a short time of its birth.

Given names which form a recognizable report

Address

Signature

Signature



799-1021026-695-  
PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of

Jefferson

APR 20 1921

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

City of

Lewisville

Registration District No.

98

File No.

S 89564

No.

St.

Hospital

Primary Registration District No.

2176

Registered No.

33

FULL NAME OF CHILD

Griffith

Sex of  
Child

M

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and

Number  
in order  
of birthLegiti-  
mate?

yes

Date of  
Birth

1-2-21

(Month) (Day) (Year)

FULL  
NAMEFATHER  
Kimball Earl GriffithFULL  
MAIDEN  
NAMEMOTHER  
Florence Finer

RESIDENCE

Lewisville

RESIDENCE

Lewisville

COLOR

W

AGE AT LAST  
BIRTHDAY29  
(Years)

COLOR

W

AGE AT LAST  
BIRTHDAY24  
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Miss.

OCCUPATION

Farmer

OCCUPATION

at home

Number of child of this mother, including present birth

1

Number of children of this mother now living, including present birth

0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

Stillborn at 130 P.-M.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

O. F. Call

(Physician or midwife)

Given names added from a supplemental report.

19

Address

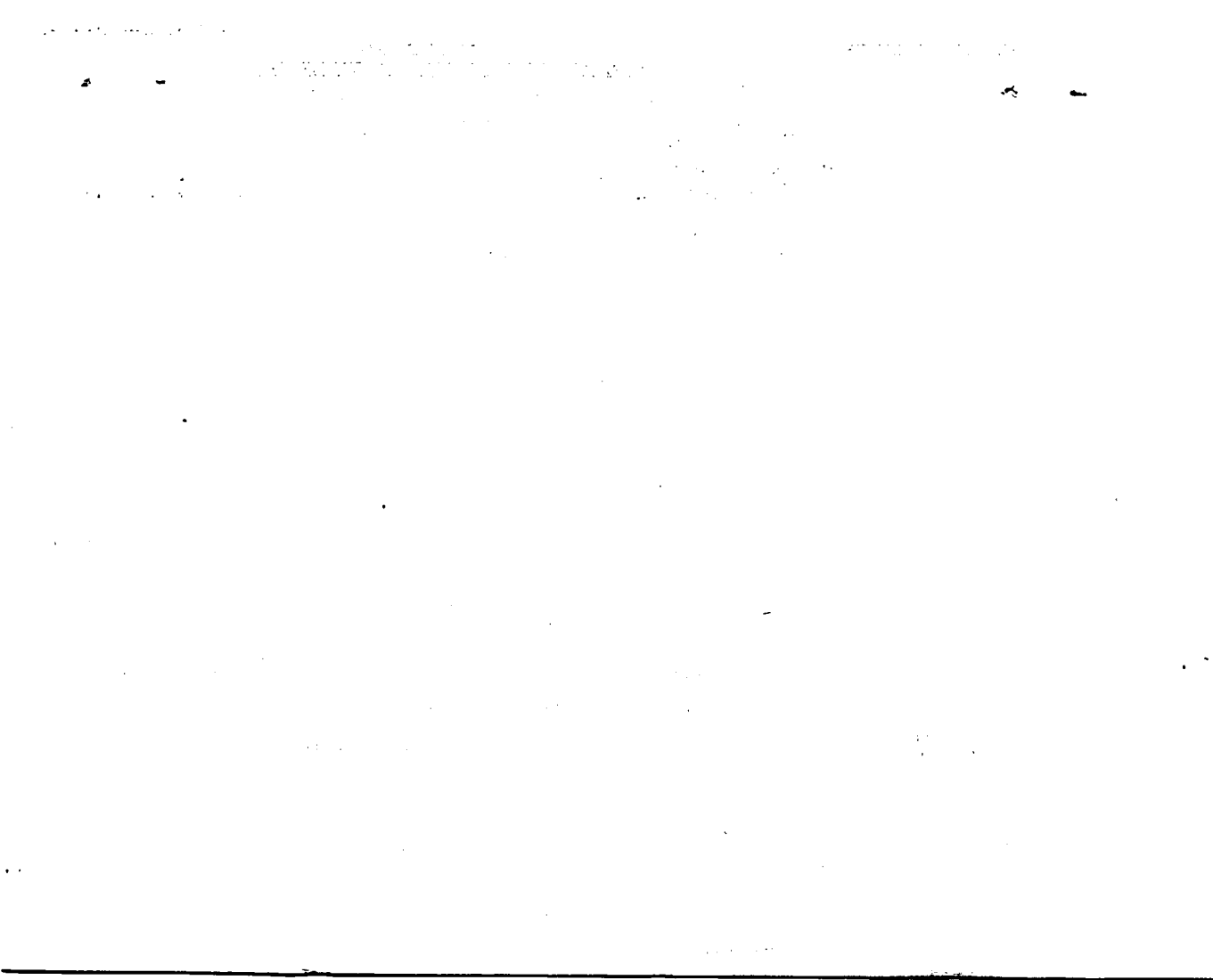
Rugby

Filed

4-10-21 Ray Fisher

Registrar.

Registrar.



RECEIVED

## CERTIFICATE OF DEATH

APR 20 1921

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Registration District No.

STATISTICS

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

1-3-21

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

699-230-028-438

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Kootenai

City of Edg

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD (unnamed)

Registration District NATAL 30

Primary Registration District No. 1057

File No. \_\_\_\_\_

Registered No. 974

RECEIVED  
MAY 7 1921  
BUREAU OF VITAL STATISTICS

S 89585

Sex of Child <u>female</u>	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>April 30</u> 19 <u>21</u> (Month) (Day) (Year)
----------------------------	--	-----	--------------------------------	----------------------------	---

FULL NAME FATHER James H. Wright

RESIDENCE Post Falls, Ida

COLOR white AGE AT LAST BIRTHDAY 54  
(Years)

BIRTHPLACE Idaho

OCCUPATION farmer

FULL MAIDEN NAME Mother The Queen

RESIDENCE Post Falls, Ida

COLOR white AGE AT LAST BIRTHDAY 44  
(Years)

BIRTHPLACE Idaho

OCCUPATION housewife

Number of child of this mother, including present birth 8 Number of children of this mother now living, including present birth 7

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 5:00 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Frank V. ...  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Post Falls, Ida  
Filed May 4 1921 DD Drenna  
Registrar

2820

Registered No.

Primary Registration District No.

1. 10-20H

FILED TO MAY 24 1964

to 252  
6114)

Number  
order in  
ship to  
to event

also  
test  
other  
to be answered only by answers to it)

FATHER

MAJOR  
FULL

**MOTHER**

**उ० म० पु० अ०**

REFERENCE

color.

AGE AT LAST  
BIRTHDAY

YACHTING

BIRTHPLACE

30A19HTR18

NOTATION

OCUPATION

Number of kind of this mother, including present birth \_\_\_\_\_  
Number of children of this mother now living, including present birth \_\_\_\_\_

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

1. I hereby certify that I attended the birth of this child, who was born alive or stillborn.

When there was no attending physician or midwife then the father, doctor, etc., should use this remedy. A salt-water enema and the mother's breasts not show other symptoms of life after birth.

Given names added from a supplemental report.

የጸሐፊው ስም

— 504 —

**2007-08-01**

**15-00000**

RECEIVED BY THE NEW YORK OFFICE OF THE DISTRICT ATTORNEY  
JAN 21 1934  
The above named person is a resident of the City of New York and is a member of the New York State Bar Association. He is a resident of the City of New York and is a member of the New York State Bar Association. He is a resident of the City of New York and is a member of the New York State Bar Association.

WALTON RESEARCH FOR PIVOTAL

RECEIVED  
JUN 20 1921  
BUREAU OF VITAL  
STATISTICS

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, ..... JUN 7 1921 ..... 192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City .....  
Street *Hansen Lake* .....  
County *Boatman* .....

File Number ..... *89583* .....

Registration Dist. No. .... *30* .....

Sex of Child..... *female* .....

Date of Birth *April 31* ..... 1921 .....

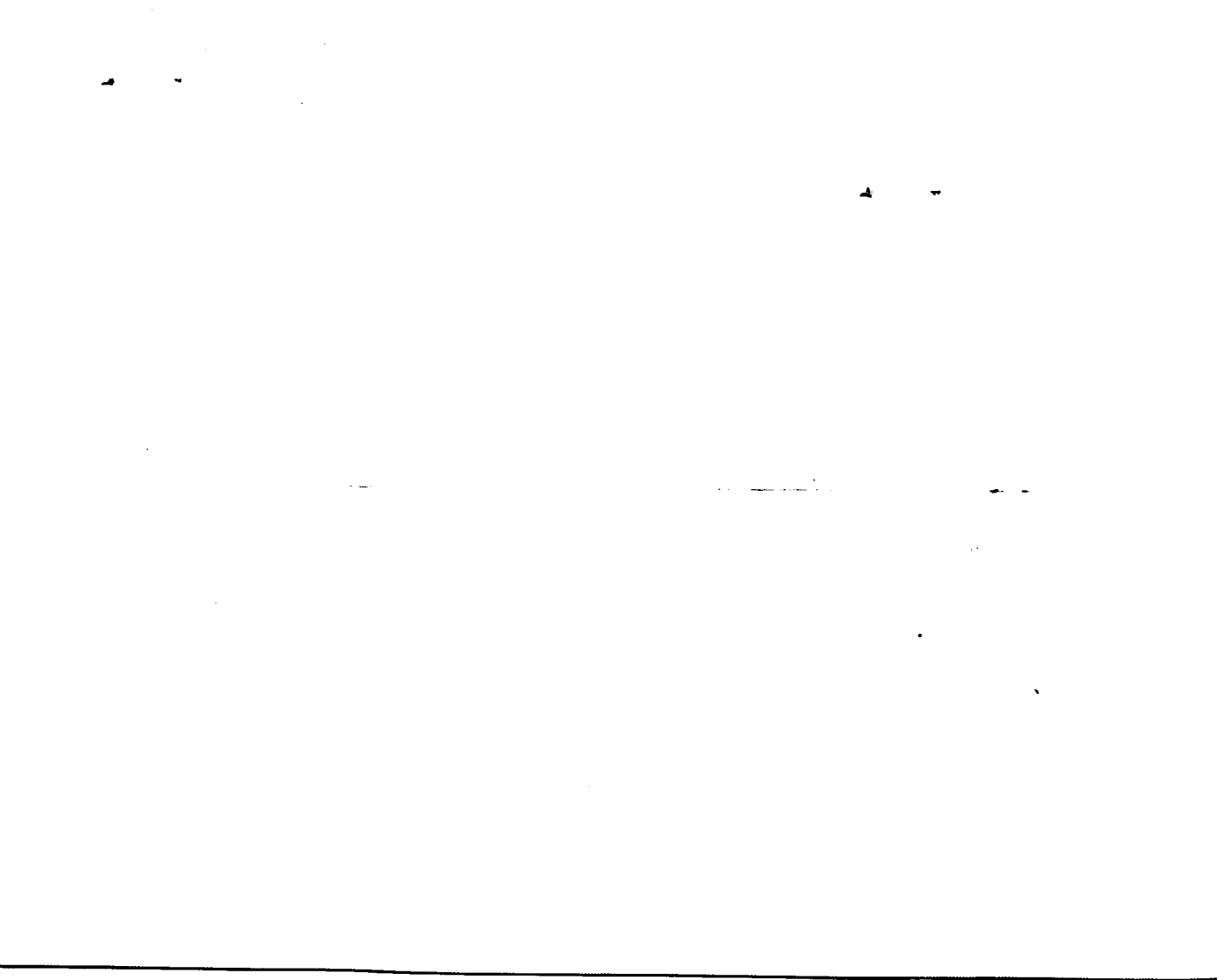
Father ..... *J. H. Wright* .....  
Full Name

Mother ..... *Marble Mc Ginn* .....  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Wright, not named died at birth* .....  
Child's Name in Full

..... *J. H. Wright* .....  
Signature of Father or Mother





## 1. PLACE OF DEATH

County of *Post Falls*  
 City of *Post Falls*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## RECEIVED CERTIFICATE OF DEATH

MAY 7 1921

BUREAU OF VITAL STATISTICS

Registration District No. *30*  
 Primary Registration District No. *1057*  
 (St.)

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. *33880*  
 Registered No. *918*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*  
 (Write the word.)

6. DATE OF BIRTH *April 30 1921*  
 (Month) (Day) (Year)

7. AGE *—* Yrs. *—* Mos. *—* ds. IF LESS than 1 day how many *—* hrs. or *—* min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work. *None*  
 (b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) *Idaho*

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *James H. Wright*(Address) *Post Falls, Idaho*

## 15.

Filled *May 4 1921* *DD Drema*  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*April 30 1921*  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 *—* to 19 *—*  
 that I last saw h *—* alive on 19 *—*  
 and that death occurred on the date stated above, at *5:00* P. M.

## The CAUSE OF DEATH\* was as follows:

*Stroke*  
 (Duration) *—* Yrs. *—* mos. *—* ds.

Contributory *Breach - pneumonia*  
 (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.

(Signed) *Frank M. D.*  
*4/30 1921* (Address) *Post Falls, Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *—* yrs. *—* mos. *—* days. In the State *—* yrs. *—* mos. *—* days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Hamm Lake* *May 1 1921*

## 20. UNDERTAKER ADDRESS

*J. H. Wright* *Post Falls, Idaho*

189B

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

296214.029-299  
DATE OF BIRTH

RECEIVED  
MAY 10 1921

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-9-8-17

County *Butte*

City of *Lanes*

BUREAU OF VITAL  
STATISTICS

*62*

File No. **S 89607**

No. .... St.

Primary Registration District No. *2142*

Registered No. *12*

Hospital .....

FULL NAME OF CHILD

*Steel Birch*

Sex of  
Child

*F*

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and { Number  
in order  
of birth

Legiti-  
mate?

*Yes*

Date of  
Birth

*4 14 1913*  
(Month) (Day) (Year)

FULL  
NAME

FATHER

*Joe M. Moring*

RESIDENCE

*Genesee*

COLOR

*W*

AGE AT LAST  
BIRTHDAY

*37*  
(Years)

BIRTHPLACE

*Iowa*

OCCUPATION

*Farmer*

FULL  
MAIDEN  
NAME

MOTHER

*Katherine Aries*

RESIDENCE

*Genesee*

COLOR

*W*

AGE AT LAST  
BIRTHDAY

*30*  
(Years)

BIRTHPLACE

*Iowa*

OCCUPATION

*Housewife*

Number of child of this mother, including present birth. .... *5*

Number of children of this mother now living, including present birth. .... *4*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was .....  
on the date above stated.

*Robert W. P. M.*  
(Born alive or stillborn)

{ \*When there was no attending physician or  
midwife then the father, householder, etc., should  
make this return. A stillborn child is one that  
neither breathes nor shows other evidence of life  
after birth.

(Signature)

*R. W. P. M.*

(Physician or midwife)

Given names added from a supplemental report.

Address

*415-26*

Filed

*1921*

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 33882  
Registered No. 4

1. PLACE OF DEATH. RECEIVED on District No. 62  
County of Blaine Primary Registration District No. 2142  
City of Genesee (No. 1011) St.)  
BUREAU OF VITAL STATISTICS  
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Ethel Birth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W (Write the word.) 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH

4 - 14 - 1924  
(Month) (Day) (Year)

7. AGE

\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

IF LESS than 1 day  
how many \_\_\_\_ hrs. or  
\_\_\_\_ mins?

8. OCCUPATION

- (a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Genesee

10. NAME OF FATHER

Geo Brommeling

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Catherine Kries

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. H. Brommeling  
Genesee

15.

Filed

4-15

1924

W. H. Brommeling

Local Registrar

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

4 - 14 - 1924  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-14 1924 to 4-14-1924, that I last saw him alive on 191\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Unborn Unborn Cord

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed)

W. H. Brommeling M. D.

4-14 1924 (Address) Genesee

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ days. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ days.

Where was disease contracted  
if not at place of death?

Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Genesee 4-15-1924

20. UNDERTAKER

ADDRESS

Geo Brommeling Genesee

189 B

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

... c. In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

County of May & June

City of BUREAU OF VITAL STATISTICS  
or STATIST.

Town of .....

(No. ....)

St.; .....

Ward) .....

FULL NAME OF CHILD

Not named (still born) Howells

If child is not yet named, make supplemental report, as directed.

Sex of Child

male

Birth  
Signature  
or other?

} and {

Number  
in order  
of birth

Legiti-  
mate?

yes

Date of  
Birth

Apr. 19, 1907  
(Month) (Day) (Year)

Full  
Name

Mrs L Berry

FATHER

Residence

Satah Co Ida

Color

White

Age at last  
Birthday

39

(Years)

Birthplace

(State or Country)

Ida

Occupation

Farmer

Full  
Maiden  
Name

Nellie May Howells

MOTHER

Residence

Satah Co Ida

Color

White

Age at last  
Birthday

37

(Years)

Birthplace

(State or Country)

Kan

Occupation

Housewife

Number of child of this mother

6

Number of children, of this mother, now living

2

### CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.\*

I hereby certify that I attended the birth of this child, and that it occurred on Apr 19, 1907 at 2 AM.

\* When there was no attending physician  
or midwife, then the father, householder, etc.,  
should make this return.

(Signature)

D. B. Harrison

Palouse Wash

(Physician or Midwife.)

Give name added from a supplemental

report

Address

Filed

April 21, 1907

D. M. Thompson  
Registrar.

Registrar.

Record No. S-89614

File No. 2 145

Registered No. 65

HTB



on



MARGIN RESERVED FOR BINDING  
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

312-205.035-962

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-22m-2-2-17

County of Nez Perce

RECEIVED

APR 16 1924

City of Leicester

BUREAU OF VITAL  
STATISTICS

S 89703

No. 417 = H.V. St.

File No. ....

Primary Registration District No. 10095

Registered No. 655

Hospital .....

FULL NAME OF CHILD

Rose Labor

Sex of Child <u>Female</u>	Twin Triplet or other? <u>  </u> (To be answered only in event of plural births)	and (Number in order of birth <u>  </u> )	Legitimate? <u>yes</u>	Date of Birth <u>3-5-1924</u> (Month) (Day) (Year)
----------------------------	---	---	------------------------	---

FULL NAME <u>Robert Labor</u>	FATHER
RESIDENCE <u>Maha, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Ellen J. Roberts</u>	MOTHER
RESIDENCE <u>Maha, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>House wife</u>	

Number of child of this mother, including present birth 1..... Number of children of this mother now living, including present birth 0.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was..... at 6 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) .....

R. J. Roberts  
(Physician or midwife)

Given names added from a supplemental report.

Address .....

Filed .....

Apr 8 19 24

Susan E. Bruce  
Registrar

# DECLARATION OF DEPENDENCY

Under the provisions of the Social Security Act, I, the undersigned, do hereby declare that I am the head of a family and that the person named herein is dependent upon me for support and maintenance.

NAME OF DEPENDENT		DATE OF BIRTH		SEX		RACE	
NAME OF HEAD OF FAMILY		DATE OF BIRTH		SEX		RACE	
ADDRESS OF HEAD OF FAMILY		CITY		STATE		ZIP	
OCCUPATION OF HEAD OF FAMILY		INDUSTRY		TRADE		PROFESSION	
OCCUPATION OF DEPENDENT		INDUSTRY		TRADE		PROFESSION	
RELATIONSHIP OF DEPENDENT TO HEAD OF FAMILY		MOTHER		FATHER		SPOUSE	
DATE OF DEPENDENCY		DATE OF BIRTH		SEX		RACE	
SIGNATURE OF HEAD OF FAMILY		SIGNATURE OF DEPENDENT		WITNESS		NOTARY	

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **33928**  
Registered No. **612**

## 1. PLACE OF DEATH

Registration District No. **96**County of **Hez. Perce**Primary Registration District No. **1009**City of **Lewiston****APR 16 1921**

St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

BUREAU OF VITAL STATISTICS

**Robert Tabor**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

**Female White****Single**  
(Write the word.)

## 6. DATE OF BIRTH

**Mar 5 1921**  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

Yrs..... Mos..... ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

**Infant**

## 9. BIRTHPLACE

(State or Country)

**Ida**

## 10. NAME OF FATHER

**Robert Tabor**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Iowa**

## 12. MAIDEN NAME OF MOTHER

**Ellen J. Roberts**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Minn.**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**Robert Tabor**

(Address)

## 15.

Filed

**Apr 12 1921****Wm E Bruce**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Mar 5 1921**  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

**March 5 1921**, to **March 5 1921**  
that I last saw him **still with** alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH was as follows:

**Still birth - due to branch presentata**

(Duration) Yrs..... mos..... ds.

Contributory  
(Secondary)

(Duration) yrs..... mos..... ds.

(Signed)

**L. J. Pugh**

M. D.

**3/7 1921**(Address) **Lewiston, Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Lewiston Ida 3/7 1921**

## 20. UNDERTAKER

## ADDRESS

**Vassar Undertakers Lewiston**

216871

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

653-112-035-819  
PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of Nez Perce RECEIVED CERTIFICATE OF BIRTH

City of Sweetwater APR 14 1921

No. 97 District No. 97 STATIST

File No. S 89723

Hospital \_\_\_\_\_ Primary Registration District No. 2174 Registered No. 11

FULL NAME OF CHILD Dorothy Jane Fellows

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legit mate? <u>yes</u>	Date of Birth <u>3</u> <u>12</u> <u>21</u> (Month) (Day) (Year)
----------------------------	---	-------	--------------------------------	---------------------------	--

FATHER  
FULL NAME William B. Fellows  
RESIDENCE Sweetwater Ida.  
COLOR White AGE AT LAST BIRTHDAY 21  
(Years)  
BIRTHPLACE Oregon  
OCCUPATION Labarer

MOTHER  
FULL MAIDEN NAME Edna F. Hart  
RESIDENCE Sweetwater Ida.  
COLOR White AGE AT LAST BIRTHDAY 18  
(Years)  
BIRTHPLACE Oregon  
OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 6:30 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) George G. Gorman  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Oldsloe Idals.  
Filed Apr. 9th 1921 L. Riggs  
Registrar

# STATE OF NEW YORK

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE LAW IN THE STATE OF NEW YORK ONLY. IT IS NOT VALID IN ANY OTHER STATE OR COUNTRY.

PLACE OF BIRTH

STATE OF NEW YORK

Form V-2 No. 11-C-35m-7-51-18

File No. 88733

Primary Registration District No. 12174 Registered No. 1

FULL NAME OF CHILD

Sex of Child

Is the reported date of birth (To be answered only in event of doubt)

Date of Birth (Month) (Day) (Year)

FULL NAME

FATHER

FULL NAME

RESIDENCE

RESIDENCE

COLOR

COLOR

AGE AT LAST BIRTHDAY (Year)

AGE AT LAST BIRTHDAY (Year)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth

CERTIFICATE ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (born alive or stillborn)

When there was an attending physician or midwife, the name of the physician or midwife who attended the birth of this child is (Name of physician or midwife)

Given names added from a subsequent report

Signature

Signature

# STATE OF IDAHO

## DEPARTMENT OF PUBLIC WELFARE

RECEIVED  
JUN 20 1921  
BUREAU OF VITAL  
STATISTICS

Boise, Idaho, ..... JUN 4 1921 ..... 192...

Dear Madam:

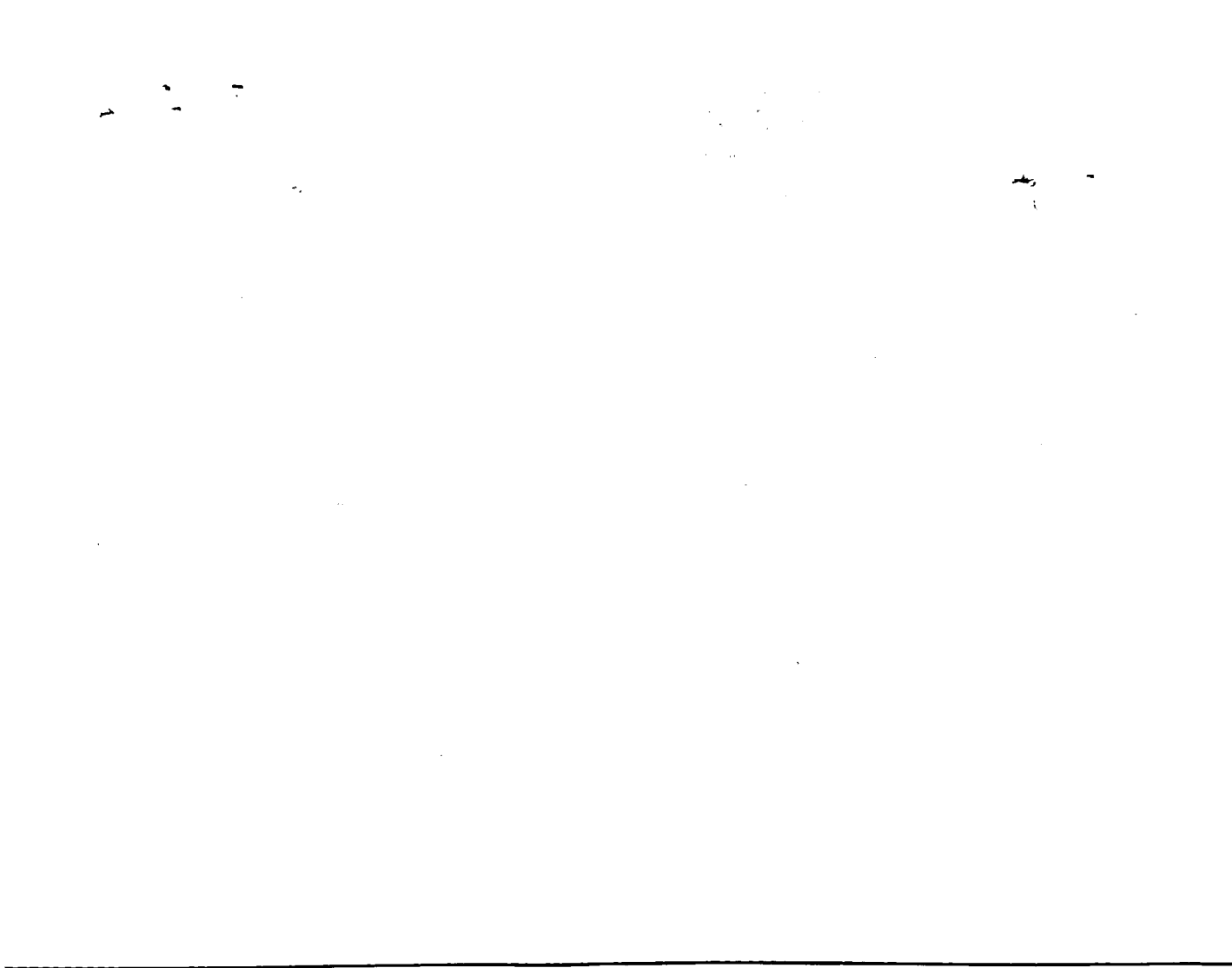
The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City Sweet Water .....  
Street .....  
County Myer .....  
Sex of Child Female .....  
Date of Birth March 12 ..... 1921  
File Number 89723 .....  
Registration Dist. No. 97 .....  
Father William Richard Fellows ..... Mother Edna Fay Hart .....  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Dorothy Jane Fellows .....  
Child's Name in Full  
Mrs Edna F Fellows .....  
Signature of Father or Mother





FORM V. S. No. 5-25 M. 1-19.

## 1. PLACE OF DEATH

County of *Nez Perce*City of *Sweetwater*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## CERTIFICATE OF DEATH

Registration District No. *128*Registration District No. *Culdesac*

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *34323*

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Female White*

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

*March 12 21*  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country) *Idaho*

## 10. NAME OF FATHER

*William R. Bellows*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Oregon*

## 12. MAIDEN NAME OF MOTHER

*Edna H. Hart*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Oregon*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs E. D. Hart*(Address) *Culdesac Ida*

## 15.

Filed *March 19 21**George Gaignard*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*March 12 21*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

.....19....., to .....19.....

that I last saw him..... alive on .....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH\* was as follows:

*Stillbirth*

.....(Duration) .....Yrs.....mos.....ds.

Contributory  
(Secondary)

.....(Duration) .....Yrs.....mos.....ds.

(Signed) *George Gaignard**B. 19 21* (Address) *Culdesac Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days. In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Culdesac Ida* .....19.....20. UNDERTAKER *W. R. Bellows* *Sweetwater*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

866-2141039-695

Form V. S. No. 11-C--25m-7-21-19

## PLACE OF BIRTH

RECEIVED STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

S 89786

County of PowerCity of American Falls

APR 26 1921  
BUREAU OF VITAL  
STATISTICS

Registration District No. 25File No. 6No. 2 St. Hospital Primary Registration District No. 2072 Registered No. 999FULL NAME OF CHILD Still-born Howell

Sex of Child Female Twin - Triplet - or other? - and - Number in order of birth - Legitimate? yes Date of Birth Feb 14 21  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME James Albert HowellRESIDENCE American Falls, IdaCOLOR White AGE AT LAST BIRTHDAY 23  
(Years)BIRTHPLACE KansasOCCUPATION Bank ClerkMOTHER  
FULL MAIDEN NAME Ruth WinegardnerRESIDENCE American Falls, IdaCOLOR White AGE AT LAST BIRTHDAY 33  
(Years)BIRTHPLACE IllinoisOCCUPATION HousewifeNumber of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still born, at 4:15 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

McMurtre, M.D.  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

19

Address Sheilder, IdaFiled 4-25 19 21

Registrar

Registrar R. J. North

RECEIVED FOR DEPARTMENT OF HEALTH  
 COUNTY OF ALBANY  
 OFFICE OF THE CLERK  
 ALBANY, N.Y.  
 JAN 10 1910

COUNTY OF ALBANY  
 OFFICE OF THE CLERK  
 ALBANY, N.Y.  
 JAN 10 1910

FIRST NAME OF CHILD  
 LAST NAME OF CHILD  
 SEX OF CHILD  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 COLOR  
 AGE AT LAST BIRTHDAY  
 BIRTHPLACE  
 OCCUPATION  
 CERTIFICATE OF ATTENDING PHYSICIAN  
 SIGNATURE OF PHYSICIAN  
 SIGNATURE OF CLERK  
 DATE

## 1. PLACE OF DEATH

County of Power  
 City of American Falls

If death occurs away from  
 usual residence, give facts  
 called for under special  
 information.

## 2. FULL NAME

RECEIVED  
 CERTIFICATE OF DEATH  
 Registration District No. 25-33960  
 Primary Registration District No. 2172  
 BUREAU OF VITAL STATISTICS  
 (No. 119)

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 3Registered No. 119

If death occurred in a hos-  
 pital, institution or camp,  
 give its NAME instead of  
 street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.

Female white Single  
 (Write the word.)

## 6. DATE OF BIRTH.

Feb 14 1921  
 (Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs. or  
 min. 2

## 8. OCCUPATION

(a) Trade, profession or  
 particular kind of work  
 (b) General nature of in-  
 dustry, business, or estab-  
 lishment in which employ-  
 ed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

James Albert Howell

## 11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

## 12. MAIDEN NAME OF MOTHER

Beryl Vinegardner

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

J. A. Howell

(Address)

American Falls Ida

## 15.

Filed

4-25-1921 R. F. Noth.  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Feb 14 1921  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Perinatal birth  
8th month

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed) McNair M. D.

2-14-21 (Address) American Falls

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)  
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place In the  
 of death. yrs. mos. days State. yrs. mos. days

Where was disease contracted  
 if not at place of death?

Former or  
 usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Inner Hall 2-14-1921

## 20. UNDERTAKER

## ADDRESS

1512

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

362-1081042-753

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of Twin Falls

RECEIVED

CERTIFICATE OF BIRTH

City of Twin Falls

APR 14 1921

No. 137 Maple St.Registration District No. 37  
STATISTICSFile No. S 89866Hospital ✓Primary Registration District No. 1085

Registered No. \_\_\_\_\_

FULL NAME OF CHILD ✓

Sex of Child <u>M</u>	Twin Triplet or other? <u>✓</u> and <u>✓</u>	Number in order of birth <u>✓</u>	Legitimate? <u>yes</u>	Date of Birth <u>March 8</u> 1921 (Month) (Day) (Year)
(To be answered only in event of plural births)				

FATHER  
FULL NAME Chas. P. Cosgriff  
RESIDENCE 137 Maple St Twin Falls Ida  
COLOR M. AGE AT LAST BIRTHDAY 46 (Years)  
BIRTHPLACE Dover Ky  
OCCUPATION Sign painter

MOTHER  
FULL MAIDEN NAME Bessie M. Peterson  
RESIDENCE 137 Maple St  
COLOR W AGE AT LAST BIRTHDAY 37 (Years)  
BIRTHPLACE Logan W.  
OCCUPATION Shop

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still Born, at 11:30 p M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) S. L. Brander  
(Physician or midwife)

Given names added from a supplemental report.

Address Twin Falls Ida  
Filed Mar. 15 1921 J. F. Coughlin  
Registrar

**DECEMBER TWENTY-NINE IS AN ANNIVERSARY FOR THE PEOPLE OF NEW YORK STATE BECAUSE A CHILD IN EVERY TWO YEARS DIES BEFORE HE REACHES HIS FIRST BIRTHDAY.**

FD-302 (Rev. 11-27-70)



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

693-123:042-385  
PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of Twin Falls

RECEIVED

CERTIFICATE OF BIRTH

City of Twin Falls

APR 14 1921

Registration District No. 37

File No.

S 89872

No. \_\_\_\_\_ St.

STATISTICS

Hospital County

Primary Registration District No. 085

Registered No.

FULL NAME OF CHILD

Wilson

Sex of Child

m

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and  
Number  
in order  
of birth

Legitt  
mate?

Ye

Date of Birth

Mar 23 1921

(Month) (Day) (Year)

FULL NAME

FATHER

Tom Gilbert Wilson

RESIDENCE

Elgin Buhl Idaho

COLOR

White

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

Illinois

OCCUPATION

Farmer

FULL MAIDEN NAME

MOTHER

Elizabeth Cherry

RESIDENCE

Buhl Idaho

COLOR

White

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

Missouri

OCCUPATION

Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

A. L. Anderson  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

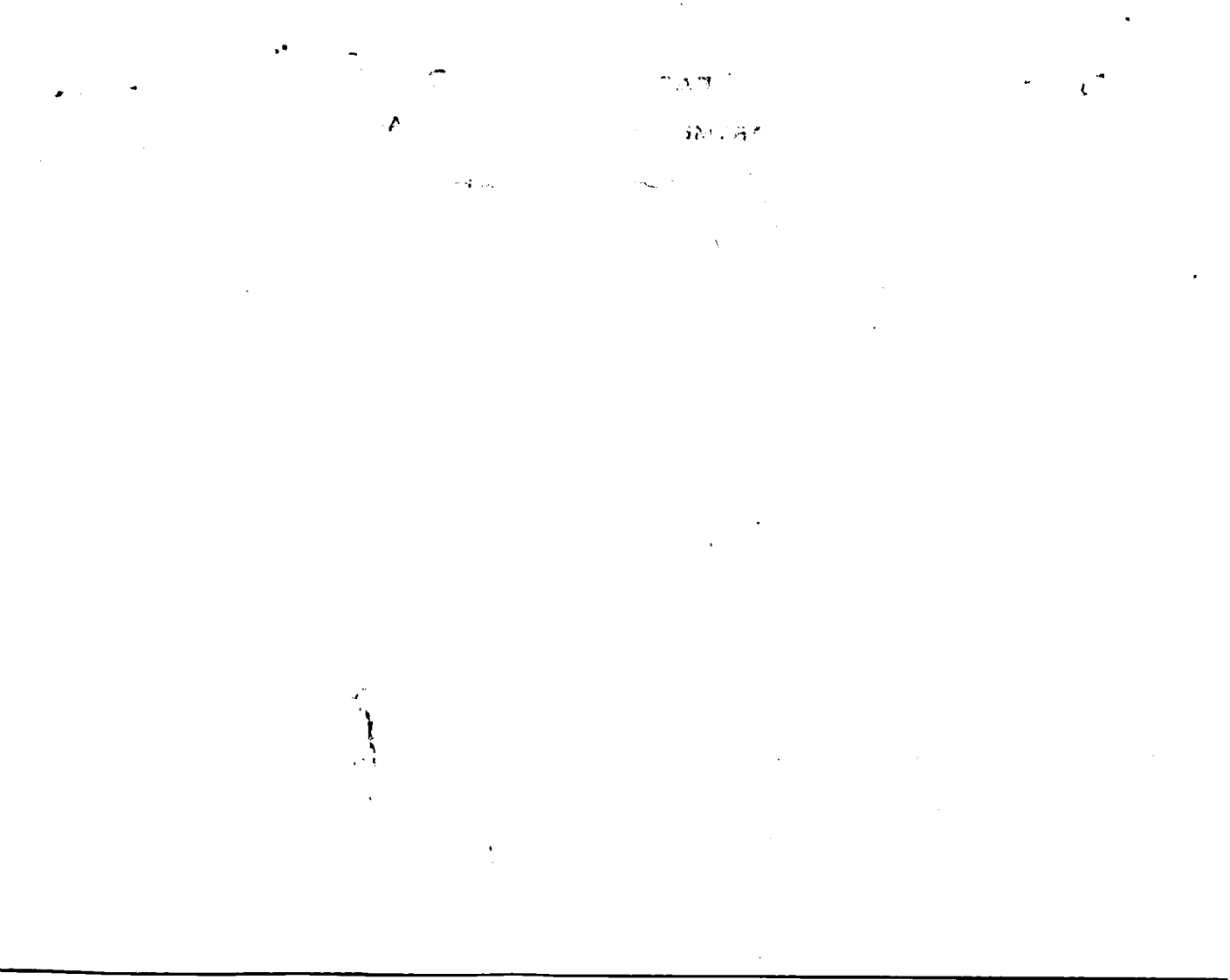
Twin Falls

Filed

Mar. 31 - 1921

John X. Coughlin  
Registrar

Registrar



REC'D  
AUG 9 1921  
BUREAU OF VITAL

Boise, Idaho,.....JUN. 8 ...1921.....192...

Dear Madam:

The name of ~~your~~ baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place { City *Twin Falls*.....  
of { Street *County Hospital*.....  
Birth { County *Twin Falls*.....

File Number ..... *89872* .....

Registration Dist. No. .... *37* .....

Sex of Child..... *male* .....

Date of Birth *March 23*.....1921.....

Father *Tom Gilbert Wilson*.....  
Full Name

Mother *Elizabeth Pearl Cho*.....  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*The baby was a "Still Born" child and not*.....  
Child's Name in Full

*Elizabeth P. Wilson*.....  
Signature of Father or Mother

2  
erry.

named,

FORM V. S. No. 5-25 M. 1-19.

## RECEIVED CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Laramie Falls  
City of Boise

APR 9 1921

BUREAU OF VITAL  
STATISTICS

Registration District No. ....

Primary Registration District No. ....

2087

St.)

File No. 33615

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Martha Lucy Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

## 6. DATE OF BIRTH

March 24 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)None

## 9. BIRTHPLACE

(State or Country)

Laramie Falls

## 10. NAME OF FATHER

H. G. Wilson

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Pearl Cherry

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Wilson

(Address)

Boise Idaho

## 15.

Filed 3-24 1921

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

March 24 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

March 24 1921, to March 24 1921  
that I last saw him alive on March 24 1921  
and that death occurred on the date stated above, at 10:30 P.M.  
The CAUSE OF DEATH\* was as follows:Stroke

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) S. L. Anderson M. D.Address Laramie Falls, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Boise Cemetery 3-24 1921

## 20. UNDERTAKER

## ADDRESS

Howells & Sons, Boise, Idaho

18912

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

959-1180427 693

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of Twin Falls

City of Twin Falls

RECEIVED

APR 14 1921

BUREAU OF VITAL STATISTICS

District No. 37

File No.

S 89873

No. \_\_\_\_\_ St.

Hospital County

Primary Registration District No. 1085

Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Baby Reid

Sex of Child

Male

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and

Number  
in order  
of birth

Legiti  
mate?

yes

Date of Birth

Mar. 18 1921  
(Month) (Day) (Year)

FULL NAME

Clifford Reid

FATHER

FULL MAIDEN NAME

Hazel Wilson

MOTHER

RESIDENCE

Twin Falls Idaho

RESIDENCE

Twin

COLOR

White

AGE AT LAST BIRTHDAY

38  
(Years)

COLOR

White

AGE AT LAST BIRTHDAY

21  
(Years)

BIRTHPLACE

Nebraska

BIRTHPLACE

Nebraska

OCCUPATION

husband

OCCUPATION

Housewife

Number of child of this mother, including present birth. 1 Number of children of this mother now living, including present birth. 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at \_\_\_\_\_ M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

D. L. Anderson  
Phys.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Twin Falls Ida

Filed

Mar 31 1921

John D. Laughlin  
Registrar

Registrar

# WYOMING RECEIVED FOR BIRMINGHAM

THIS IS A STATEMENT OF RECORD  
 MADE BY THE BIRMINGHAM RECORDING OFFICE IN THE CITY OF BIRMINGHAM  
 IN THE YEAR 1911. THE NAME OF THE CHILD IS VIVIAN L. BIRMINGHAM  
 THE NAME OF THE MOTHER IS VIVIAN L. BIRMINGHAM  
 THE NAME OF THE FATHER IS VIVIAN L. BIRMINGHAM  
 THE NAME OF THE CHILD IS VIVIAN L. BIRMINGHAM

Form V. 2, No. 11-C-22m-7-21-19

**RECEIVED**  
**APR 14 1911**  
**CERTIFICATE OF BIRTH**

County of \_\_\_\_\_  
 City of \_\_\_\_\_  
 State of \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

Full Name of Child \_\_\_\_\_  
 Sex of Child \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Time of Birth \_\_\_\_\_  
 Place of Birth \_\_\_\_\_

Full Name of Father \_\_\_\_\_  
 Residence \_\_\_\_\_  
 Color \_\_\_\_\_  
 Age at Last Birthday \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Occupation \_\_\_\_\_

Full Name of Mother \_\_\_\_\_  
 Residence \_\_\_\_\_  
 Color \_\_\_\_\_  
 Age at Last Birthday \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Occupation \_\_\_\_\_

Number of children of this mother, including present birth, \_\_\_\_\_  
 Number of children of the mother now living, including present birth, \_\_\_\_\_

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.  
 I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
 (Name of Physician or Midwife)  
 (Signature)  
 (Physician or Midwife)

Given names taken from a registered report.  
 (When there was no attending physician or midwife, the father, mother, or other person should make this report. A registered child is one that has been recorded in the birth records of the city of Birmingham.)

Filed \_\_\_\_\_  
 Address \_\_\_\_\_



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

APR 14 1921

37

County of

Curie Falls

Registration District No.

1085

City of

Curie Falls

BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Betty Reid

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

33988

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single

6. DATE OF BIRTH

March 18 1921

7. AGE

1 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Clifford Reid

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Hazel Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clifford Reid

(Address)

Curie Falls

15.

March 23 1921

J. J. Laughlin  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18 1921

17. I HEREBY CERTIFY, That I attended deceased from

March 18 1921, to March 18 1921  
that I last saw him born dead 19  
and that death occurred on the date stated above, at 8 P.M.  
The CAUSE OF DEATH\* was as follows:

Premature Birth Small for in  
mother & child

(Duration) Yrs. mos. f. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

S. R. Brown Dr  
Curie Falls Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURNAL OR REMOVAL

DATE OF BURIAL

Curie Falls

3/21 1921

20. UNDERTAKER

ADDRESS

J. J. Laughlin

Curie Falls

151a

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

619.127.044-669

PLACE OF BIRTH

County of Washington

City of Musie

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

RECEIVED  
APR 21 1921

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Registration District No. 86

Primary Registration District No. 2112

File No. S 89945

Registered No. 63

Sex of Child Male { Twin Triplet or other? } and { Number in order of birth } Legit mate? yes Date of Birth March 27 19 21  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Claude Ward  
RESIDENCE Musie Ida R4D 112  
COLOR white AGE AT LAST BIRTHDAY 35 (Years)  
BIRTHPLACE Ill.  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Nellie Forest  
RESIDENCE Musie Ida  
COLOR white AGE AT LAST BIRTHDAY 32 (Years)  
BIRTHPLACE Colorado  
OCCUPATION Housewife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 9 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. R. H. Haulm M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address \_\_\_\_\_

Filed 4/1/21 19

Registrar

Registrar

I hereby certify that I attended the birth of this child, who was  
 (Name of child or stillborn)  
 born at (Place of birth)  
 on the (Date of birth) day of (Month) 19(Year)  
 at (Place of birth)  
 (Signature)  
 (Position of midwife)  
 Number of child of this mother, including present birth  
 Number of children of this mother now living, including present birth  
 Date of birth of child (Month) 19(Year)

10  
 11  
 12  
 13  
 14  
 15  
 16  
 17  
 18  
 19  
 20  
 21  
 22  
 23  
 24  
 25  
 26  
 27  
 28  
 29  
 30  
 31  
 32  
 33  
 34  
 35  
 36  
 37  
 38  
 39  
 40  
 41  
 42  
 43  
 44  
 45  
 46  
 47  
 48  
 49  
 50  
 51  
 52  
 53  
 54  
 55  
 56  
 57  
 58  
 59  
 60  
 61  
 62  
 63  
 64  
 65  
 66  
 67  
 68  
 69  
 70  
 71  
 72  
 73  
 74  
 75  
 76  
 77  
 78  
 79  
 80  
 81  
 82  
 83  
 84  
 85  
 86  
 87  
 88  
 89  
 90  
 91  
 92  
 93  
 94  
 95  
 96  
 97  
 98  
 99  
 100  
 101  
 102  
 103  
 104  
 105  
 106  
 107  
 108  
 109  
 110  
 111  
 112  
 113  
 114  
 115  
 116  
 117  
 118  
 119  
 120  
 121  
 122  
 123  
 124  
 125  
 126  
 127  
 128  
 129  
 130  
 131  
 132  
 133  
 134  
 135  
 136  
 137  
 138  
 139  
 140  
 141  
 142  
 143  
 144  
 145  
 146  
 147  
 148  
 149  
 150  
 151  
 152  
 153  
 154  
 155  
 156  
 157  
 158  
 159  
 160  
 161  
 162  
 163  
 164  
 165  
 166  
 167  
 168  
 169  
 170  
 171  
 172  
 173  
 174  
 175  
 176  
 177  
 178  
 179  
 180  
 181  
 182  
 183  
 184  
 185  
 186  
 187  
 188  
 189  
 190  
 191  
 192  
 193  
 194  
 195  
 196  
 197  
 198  
 199  
 200  
 201  
 202  
 203  
 204  
 205  
 206  
 207  
 208  
 209  
 210  
 211  
 212  
 213  
 214  
 215  
 216  
 217  
 218  
 219  
 220  
 221  
 222  
 223  
 224  
 225  
 226  
 227  
 228  
 229  
 230  
 231  
 232  
 233  
 234  
 235  
 236  
 237  
 238  
 239  
 240  
 241  
 242  
 243  
 244  
 245  
 246  
 247  
 248  
 249  
 250  
 251  
 252  
 253  
 254  
 255  
 256  
 257  
 258  
 259  
 260  
 261  
 262  
 263  
 264  
 265  
 266  
 267  
 268  
 269  
 270  
 271  
 272  
 273  
 274  
 275  
 276  
 277  
 278  
 279  
 280  
 281  
 282  
 283  
 284  
 285  
 286  
 287  
 288  
 289  
 290  
 291  
 292  
 293  
 294  
 295  
 296  
 297  
 298  
 299  
 300  
 301  
 302  
 303  
 304  
 305  
 306  
 307  
 308  
 309  
 310  
 311  
 312  
 313  
 314  
 315  
 316  
 317  
 318  
 319  
 320  
 321  
 322  
 323  
 324  
 325  
 326  
 327  
 328  
 329  
 330  
 331  
 332  
 333  
 334  
 335  
 336  
 337  
 338  
 339  
 340  
 341  
 342  
 343  
 344  
 345  
 346  
 347  
 348  
 349  
 350  
 351  
 352  
 353  
 354  
 355  
 356  
 357  
 358  
 359  
 360  
 361  
 362  
 363  
 364  
 365  
 366  
 367  
 368  
 369  
 370  
 371  
 372  
 373  
 374  
 375  
 376  
 377  
 378  
 379  
 380  
 381  
 382  
 383  
 384  
 385  
 386  
 387  
 388  
 389  
 390  
 391  
 392  
 393  
 394  
 395  
 396  
 397  
 398  
 399  
 400  
 401  
 402  
 403  
 404  
 405  
 406  
 407  
 408  
 409  
 410  
 411  
 412  
 413  
 414  
 415  
 416  
 417  
 418  
 419  
 420  
 421  
 422  
 423  
 424  
 425  
 426  
 427  
 428  
 429  
 430  
 431  
 432  
 433  
 434  
 435  
 436  
 437  
 438  
 439  
 440  
 441  
 442  
 443  
 444  
 445  
 446  
 447  
 448  
 449  
 450  
 451  
 452  
 453  
 454  
 455  
 456  
 457  
 458  
 459  
 460  
 461  
 462  
 463  
 464  
 465  
 466  
 467  
 468  
 469  
 470  
 471  
 472  
 473  
 474  
 475  
 476  
 477  
 478  
 479  
 480  
 481  
 482  
 483  
 484  
 485  
 486  
 487  
 488  
 489  
 490  
 491  
 492  
 493  
 494  
 495  
 496  
 497  
 498  
 499  
 500  
 501  
 502  
 503  
 504  
 505  
 506  
 507  
 508  
 509  
 510  
 511  
 512  
 513  
 514  
 515  
 516  
 517  
 518  
 519  
 520  
 521  
 522  
 523  
 524  
 525  
 526  
 527  
 528  
 529  
 530  
 531  
 532

MAURICE REBEKAL FOR HINDING  
 AGAINST YULY ALAN LILADON LIL—THIS IS A LEGISLATIVE RECORD  
 OF THE HOUSE OF REPRESENTATIVES OF THE STATE OF NEW YORK  
 FOR THE YEAR 1900

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, ..... JUN 4 1921 .....

RECEIVED  
JUN 2  
BUREAU OF  
STATISTICS

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Weniger*  
Street *R. F. D. No. 2*  
County *Washington*

File Number *899451*

Registration Dist. No. *86*

Sex of Child *male*

Date of Birth *Mar. 27* 1921

Father *Claude Ward*  
Full Name

Mother *Hellie Ward*  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Child died at birth*  
Child's Name in Full

*Claude Ward*  
Signature of Father or Mother

RECEIVED  
17 1921  
DEPT. OF VITAL  
STATISTICS

rt-  
ow

18

Copy

593-1021001-249

## PLACE OF BIRTH

County of *Ada*City of *Bain*No. *42012*RECEIVED  
JUN 3 1921  
BUREAU OF VITAL  
STATISTICSDistrict No. *2*Primary Registration District No. *1004*Hospital *X*Full Name of Child *X*STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11—25m-6-15-18

## CERTIFICATE OF BIRTH

S 89970

File No. \_\_\_\_\_

Registered No. *209*

SEX OF CHILD <i>M.</i>	Twin Triplet or other? <i>X</i>	and	Number in order of birth (To be answered only in event of plural births) <i>1</i>	Legiti- mate? <i>Yes</i>	DATE OF BIRTH <i>May 2 21</i> (Month) (Day) (Year)
FULL NAME <i>Ray Nichols</i>			FULL MAIDEN NAME <i>Susie Lurtur</i>		
RESIDENCE <i>Bain</i>			RESIDENCE <i>Bain</i>		
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>23</i> (Years)		COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>31</i> (Years)	
BIRTHPLACE <i>Colorado</i>			BIRTHPLACE <i>Oklahoma</i>		
OCCUPATION <i>Auto Mechanic</i>			OCCUPATION <i>Housewife</i>		

Number of child of this mother, including present birth..... Number of children of this mother now living, including present birth.....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *Dr. J. J. J. J.*

(Physician or midwife)

Given names added from a supplemental report

Address \_\_\_\_\_

Filed *May 9. 21*

Registrar

Registrar





## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 34018

Registered No. 127

## 1. PLACE OF DEATH

County of Ada  
City of Boise  
Registration District No. 3  
Primary Registration District No. 1904  
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

## 2. FULL NAME

Infant Ray Nichols

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single  
(Write the word.)

## 6. DATE OF BIRTH

May 3 1921  
(Month) (Day) (Year)

## 7. AGE

Shellborn  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

man

## 9. BIRTHPLACE

(State or Country)

Boise La

## 10. NAME OF FATHER

Ray Nichols

## 11. BIRTHPLACE OF FATHER

(State or Country)

Cal.

## 12. MAIDEN NAME OF MOTHER

Lussie Zerber

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Cal.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Nichols  
211 8016

## 15.

Filed

7-9-21 1921

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 3 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/3 1921, to 5/3 1921

that I last saw him alive on 5-3 1921

and that death occurred on the date stated above, at 74 M.

The CAUSE OF DEATH\* was as follows:

Pure Born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1921

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Morrison Hill Cemetery 5/3 1921

## 20. UNDERTAKER

## ADDRESS

Schmidt &amp; Vidarson Boise

Furness

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

219-004001-735  
PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

**S 89991**

County of Ada RECEIVED  
City of Boise JUN 3 1921  
No. 1st X Bannock St. BUREAU OF VITAL STATISTICS Registration District No. 2 File No. \_\_\_\_\_  
Hospital St. Lukes Primary Registration District No. 1004 Registered No. 230  
FULL NAME OF CHILD \_\_\_\_\_

Sex of Child Female { Twin Triplet or other? } and { Number in order of birth } Legitimate? yes Date of Birth May 4 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME James Carter Kern  
RESIDENCE Parma, Idaho  
COLOR White AGE AT LAST BIRTHDAY 29 yrs. (Years)  
BIRTHPLACE Michigan  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Francis Julia Gleason  
RESIDENCE Parma, Idaho  
COLOR White AGE AT LAST BIRTHDAY 26 (Years)  
BIRTHPLACE Gates Center, Kansas  
OCCUPATION Housewife

Number of child of this mother, including present birth 1st Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was dead at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. Springer

(Physician or midwife)

Given names added from a supplemental report. \_\_\_\_\_ 19\_\_\_\_

Address \_\_\_\_\_  
Filed May 20 1921 R. A. Paul  
Registrar.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
CITY OF NEW YORK

RECEIVED  
JUN 8 1951

100002

Name of Child		Sex		Date of Birth		Place of Birth		Hospital		Physician		Maiden Name		Maiden Address		Maiden City		Maiden State		Maiden Zip	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
Mother's Name		Mother's Address		Mother's City		Mother's State		Mother's Zip		Father's Name		Father's Address		Father's City		Father's State		Father's Zip		[illegible]	
Age at Last Birthday		Color		Ethnicity		Occupation		Education		Religion		Marital Status		Date of Marriage		Place of Marriage		Date of Divorce		Place of Divorce	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
Signature of Registrar		Signature of Physician		Signature of Midwife		Signature of Nurse		Signature of Doctor		Signature of Hospital		Signature of City		Signature of State		Signature of Zip		Signature of Country		Signature of World	

THIS CARD IS TO BE FILLED BY THE REGISTRAR OR HIS ASSISTANT. IT IS NOT TO BE FILLED BY THE PHYSICIAN OR MIDWIFE. IT IS NOT TO BE FILLED BY THE HOSPITAL OR THE CITY OR THE STATE OR THE ZIP CODE.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Adair Registration District No. 2  
 City of Paris Primary Registration District No. 100  
110 East Bannock St.)

If death occurs away from  
 usual residence, give facts  
 called for under special in-  
 formation.

2. FULL NAME

Baby Karen

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 34019Registered No. 12

If death occurred in a hos-  
 pital, institution or camp,  
 give its NAME instead of  
 street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED single

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs.  
 or min.?

8. OCCUPATION

(a) Trade, profession or  
 particular kind of work  
 (b) General nature of in-  
 dustry, business or estab-  
 lishment in which employ-  
 ed (or employer)

9. BIRTHPLACE

(State or Country) Boise

10. NAME OF FATHER

John E. Karn

11. BIRTHPLACE OF FATHER

(State or Country) Minnesota

12. MOTHER'S NAME OF MOTHER

Anna Gleason

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John E. Karn  
Parama, Ida.

15. Filled

May 4 1924

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 4 1924  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 4 1924 to May 4 1924that I last saw him alive on she born 1924and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Placenta Praevia  
Placenta had separated and  
circulation to child was shut off.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

May 4 1924 (Address) Boise, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. days

Where was disease contracted if not at place of death? St. Luke's HospFormer or usual residence Parama, Ida.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parama, Idaho 5/5/24

20. UNDERTAKER

ADDRESS

Schweitzer, Volstead Ave BoiseJohn E. Karn

MARGIN RESERVED FOR BINDING  
 WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD  
 N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH  
 in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

255-225-001-43

PLACE OF BIRTH

STATE OF IDAHO

Form V. S. No. 11-C--25m-7-21-19

BUREAU OF VITAL STATISTICS

County of Ada

RECEIVED  
JUN 3 1921  
BUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

S-  
89999

City of Bowen

No. \_\_\_\_\_

Registration District No. 2  
St. \_\_\_\_\_

File No. \_\_\_\_\_

Hospital St. LukePrimary Registration District No. 1004Registered No. 238FULL NAME OF CHILD SeibelSex of  
Child F

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and  
Number  
in order  
of birth  
(To be answered only in event of plural births)

Legiti  
mate? lDate of  
Birth

May 25 1921  
(Month) (Day) (Year)

FULL  
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_, at 2:15 P.M.  
on the date above stated. (~~Respective~~ or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

Registrar

Registrar

88333

BUREAU OF VITAL STATISTICS

CERTIFICATE OF

1931

STATE OF NEW YORK

DEPARTMENT OF HEALTH

FULL NAME OF CHILD

SEX OF CHILD

RACE

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

AGE AT LAST

ETHNICITY

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I attended the birth of this child, who was

(Signature)

(Physician or midwife)

Address

Register

MAILED 1931 FEB 10 10 10 AM  
NEW YORK  
RECEIVED  
BUREAU OF VITAL STATISTICS  
DEPARTMENT OF HEALTH  
STATE OF NEW YORK



## CERTIFICATE OF DEATH

1. PLACE OF DEATH  
 County of Ida Registration District No. 2  
 City of Boise Primary Registration District No. 1224  
St. Lukes Hospital St.)  
 If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
 JUN 3 1921  
 BUREAU OF VITAL STATISTICS

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 34041  
 Registered No. 153

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

Infant Seibel

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED Single

6. DATE OF BIRTH

May 25 1921  
 (Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs.  
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None  
 (b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Theodore Seibel

11. BIRTHPLACE OF FATHER

(State or Country) Minnesota

12. MAIDEN NAME OF MOTHER

Margaret Walker

13. BIRTHPLACE OF MOTHER

(State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Theodore Seibel

15.

Filed May 25 1921 P. H. Pratt  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 25 1921  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 25 1921 to May 25 1921  
 that I last saw h. on May 25 1921  
 and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH\* was as follows:

Premature birth - Stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

May 25 1921 (Address) Boise Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

May 25 1921

20. UNDERTAKER

ADDRESS

Summers & Co.

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

236-2271003-236

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

JUN 9 1921

CERTIFICATE OF BIRTH

S 90021

County of Bannock

City of Lukom Ida

BUREAU OF VITAL STATISTICS

Registration District No. 23 File No. 72

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2141 Registered No. 3743

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Stoley

Sex of Child <u>Female</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and	Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>Apr. 27</u> 19 <u>21</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------	------------------------	---

FATHER  
FULL NAME H Stoley

RESIDENCE

Lukom Ida

COLOR

W

AGE AT LAST BIRTHDAY

43

(Years)

BIRTHPLACE

Utah

OCCUPATION

Farming

MOTHER  
FULL MAIDEN NAME

Mary Ann Stoley

RESIDENCE

Lukom

COLOR

W

AGE AT LAST BIRTHDAY

40

(Years)

BIRTHPLACE

Utah

OCCUPATION

H-W

Number of child of this mother, including present birth 9 Number of children of this mother now living, including present birth 7

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born Stillborn, at 6:30 P.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. F. Miller M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

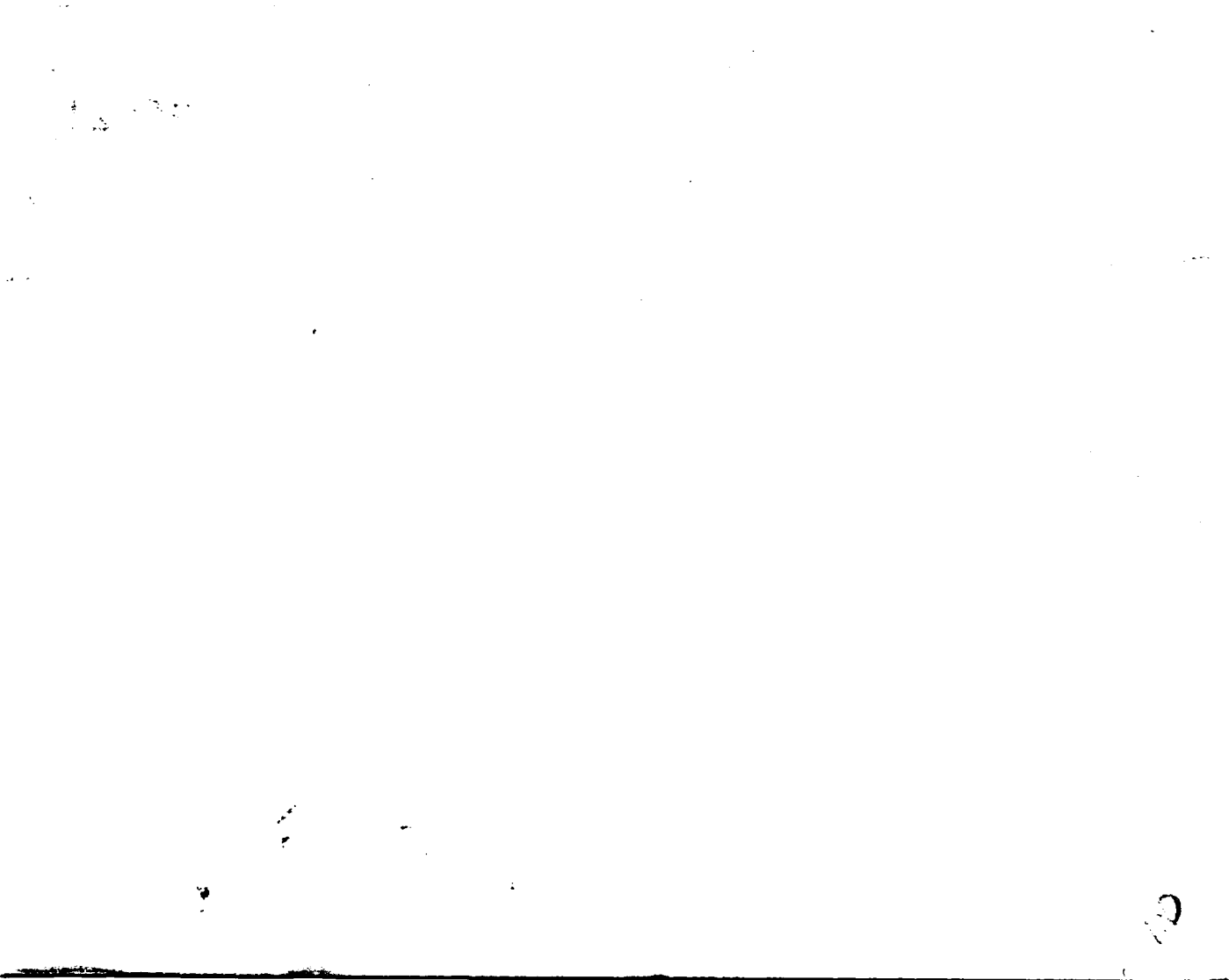
Beaumont

Filed

12/1 1921

Registrar

Registrar



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

473106.003-293

PLACE OF BIRTH

County of Bernick

City of Prattville

No. 555 So 3rd St.

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

RECEIVED STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

JUN 9 1921 CERTIFICATE OF BIRTH

BUREAU OF VITAL STATISTICS  
Registration District No. 28

File No. 72

Primary Registration District No. 261

Registered No. 3784

S 90062

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate? <u>Yes</u>	Date of Birth <u>May 6</u> 19 <u>21</u> (Month) (Day) (Year)
--------------------------	---	-----	---	-------------------------------	--

FULL NAME <u>Jerry Upton</u>	FATHER
RESIDENCE <u>555 So 3rd</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>North Carolina</u>	
OCCUPATION <u>Brakeman</u>	

FULL MAIDEN NAME <u>Enid Rithcast</u>	MOTHER
RESIDENCE <u>555 So 3rd</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Kansas City, Mo.</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was born alive, at 6:30 P. M.  
on the date above stated. (Born alive or stillborn)

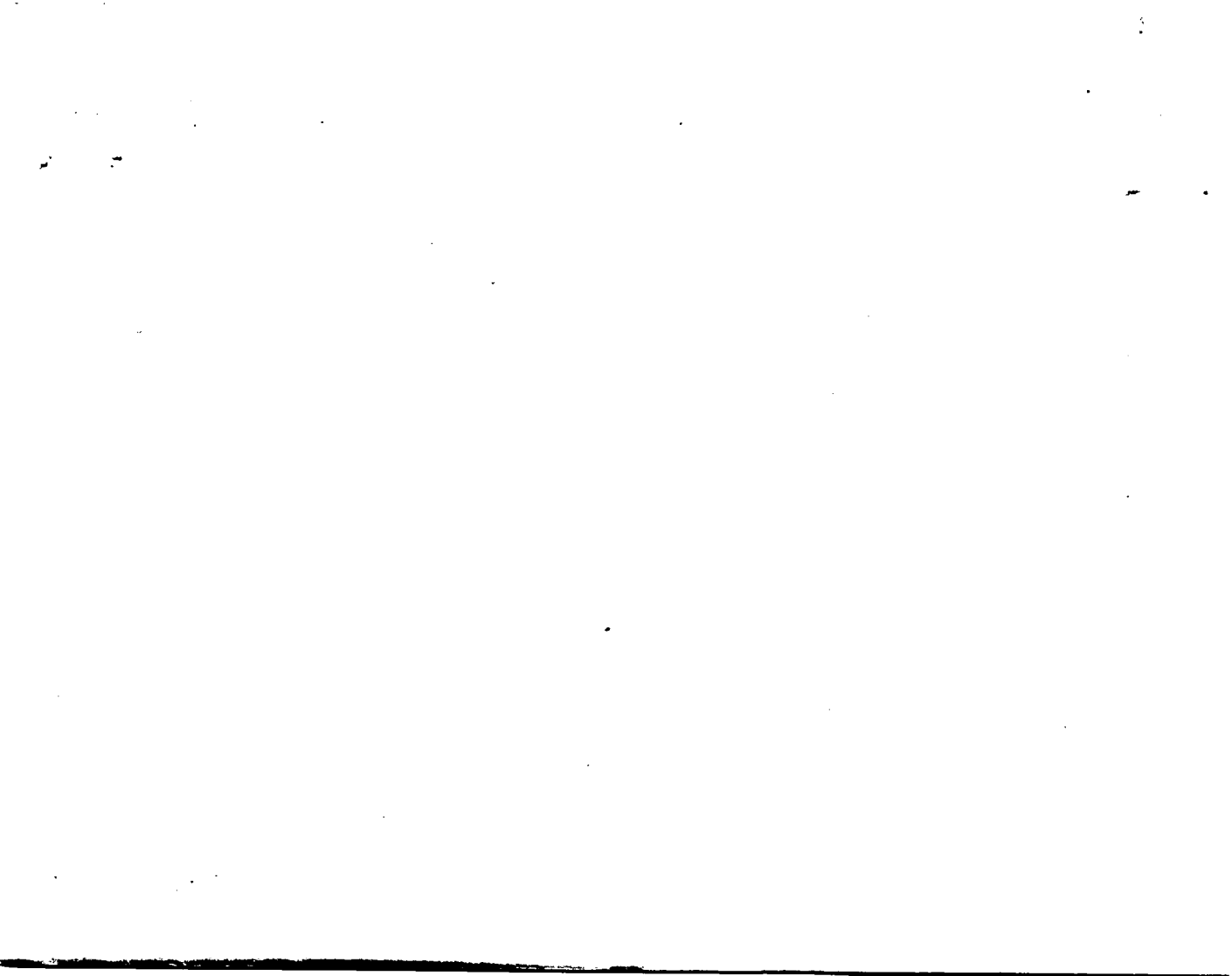
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Enid Rithcast M.D.  
(Physician or midwife)

Given names added from a supplemental report.

Address Prattville  
Filed 4/1 1921 Registrar W. J. Young

Registrar



## 1. PLACE OF DEATH

County of *Bannock*Registration District No. *28*City of *Cassida*Primary Registration District No. *214*File No. *40*Registered No. *3574*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Jessie (Upton)*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX *Male*4. COLOR OR RACE *white*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

*May 6<sup>th</sup> 1924*

(Month)

(Day)

(Year)

7. AGE

*Premature Birth*

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Idaho*10. NAME OF FATHER *Jerry Upton*

11. BIRTHPLACE OF FATHER

(State or Country) *N. Carolina*12. MAIDEN NAME OF MOTHER *Enid Kithcart*

13. BIRTHPLACE OF MOTHER

(State or Country) *Missouri*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Enid Kithcart*(Address) *555 S. Third*

15.

Filed *7/7*

1924

Local Registrar *J. P. Young*

16. DATE OF DEATH

*May 6<sup>th</sup> 1924*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*5/6 1924 to 5/6 1924*  
that I last saw him alive on *5/6 1924*  
and that death occurred on the date stated above, at *2 P.M.*

The CAUSE OF DEATH\* was as follows:

*Still born*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Enid Kithcart* (M. D.)(Address) *Peabody*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mountain View May 8 1924*

20. UNDERTAKER

ADDRESS

*Chambers, Peabody*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.*; *Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

619 2101003-763  
PLACE OF BIRTH

County of Bannock  
City of Greentell  
No. 505 So. 12<sup>th</sup> Ave. St.  
Hospital Home

RECEIVED BUREAU OF VITAL STATISTICS

JUN 9 1921 CERTIFICATE OF BIRTH **S 90076**

BUREAU OF VITAL  
STATISTICS

28

File No. 72

Primary Registration District No. 2161

Registered No. 3798

Still born.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? <u>    </u>	and	Number in order of birth <u>    </u>	Legitimate? <u>Yes</u>	Date of birth <u>May 10</u> 192 <u>1</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What bactericidal solution was used in eyes?     

Number of child of this mother, including present birth... 4 Number of child of this mother now living, including present birth... 3

FATHER		MOTHER	
FULL NAME	<u>Roy Edward Ward</u>	FULL MAIDEN NAME	<u>Lena Goldschmidt</u>
RESIDENCE	<u>505 So. 12<sup>th</sup> Ave.</u>	RESIDENCE	<u>505 So. 12<sup>th</sup> Ave.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>24</u> (Years)	AGE AT LAST BIRTHDAY	<u>26</u> (Years)
BIRTHPLACE	<u>St. Louis Mo.</u>	BIRTHPLACE	<u>St. Louis Mo.</u>
OCCUPATION	<u>O. S. L. Fireman</u>	OCCUPATION	<u>Housekeeping</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:30 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mrs. Ann M. Bird  
Midwife  
(Physician or midwife)

Give names added from a supplemental report.

Address 413 So. 4<sup>th</sup> Ave.

Filed 6/11 1921

Registrar.

Registrar.



OCT 09 2002

## CERTIFICATE OF DEATH

34061 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 96  
Registered No. 3579

## 1. PLACE OF DEATH

County of Bannock Registration District No. 28  
City of Pocatello Primary Registration District No. 2161  
City of Pocatello BUREAU OF STATISTICS (St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Ward

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Infant  
(Write the word.)

## 6. DATE OF BIRTH

May 10 1921  
(Month) (Day) (Year)

## 7. AGE

Stillborn IF LESS than 1 day how many..... hrs. or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer).

Infant

## 9. BIRTHPLACE

(State or Country) Pocatello Ida.

## 10. NAME OF FATHER

Ray E. Ward

## 11. BIRTHPLACE OF FATHER

(State or Country) St Louis Mo

## 12. MAIDEN NAME OF MOTHER

Magdalena Goldschmidt

## 13. BIRTHPLACE OF MOTHER

(State or Country) St Louis Mo.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray E. Ward  
(Address) City of Pocatello

## 15.

Filed 5/11 1921 J. P. Young  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 10 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

5/10 1921 to 5/10 1921

that I last saw him dead on 5/10 1921

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

Still Birth - Premature

(Duration) Yrs. mos. ds.

Contributory End in cord - Circulation  
(Secondary) obstructed.

(Duration) yrs. mos. ds.

(Signed) J. P. Young M. D.

5/11 1921 (Address) Pocatello

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View Bur May 11 1921

## 20. UNDERTAKER ADDRESS

Shumacher Hall Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

249-230-003-767  
PLACE OF BIRTH

County of Bannock  
City of Pocatello  
No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
RECEIVED  
JUN 9 1921  
CERTIFICATE OF BIRTH  
S90106  
BUREAU OF VITAL  
STATISTICS  
Registration District No. 25 File No. 73  
Primary Registration District No. 2141 Registered No. 8828  
Still born  
(Certificate of no value without full name of child.)

Sex of Child <u>fr</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>5 30</u> 192 <u>1</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 6 ... Number of child of this mother now living, including present birth... 5 ...

FATHER		MOTHER	
FULL NAME	<u>Francis Fredrick Suggeli</u>	FULL MAIDEN NAME	<u>Gertrude Lillian Cole</u>
RESIDENCE	<u>Pocatello</u>	RESIDENCE	<u>Pocatello</u>
COLOR	<u>wh</u>	COLOR	<u>wh</u>
AGE AT LAST BIRTHDAY	<u>39</u> (Years)	AGE AT LAST BIRTHDAY	<u>35</u> (Years)
BIRTHPLACE	<u>Switzerland</u>	BIRTHPLACE	<u>Maine</u>
OCCUPATION	<u>raucher</u>	OCCUPATION	<u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born at 3:15 a M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

Give names added from a supplemental report.

\_\_\_\_\_, 19\_\_\_\_

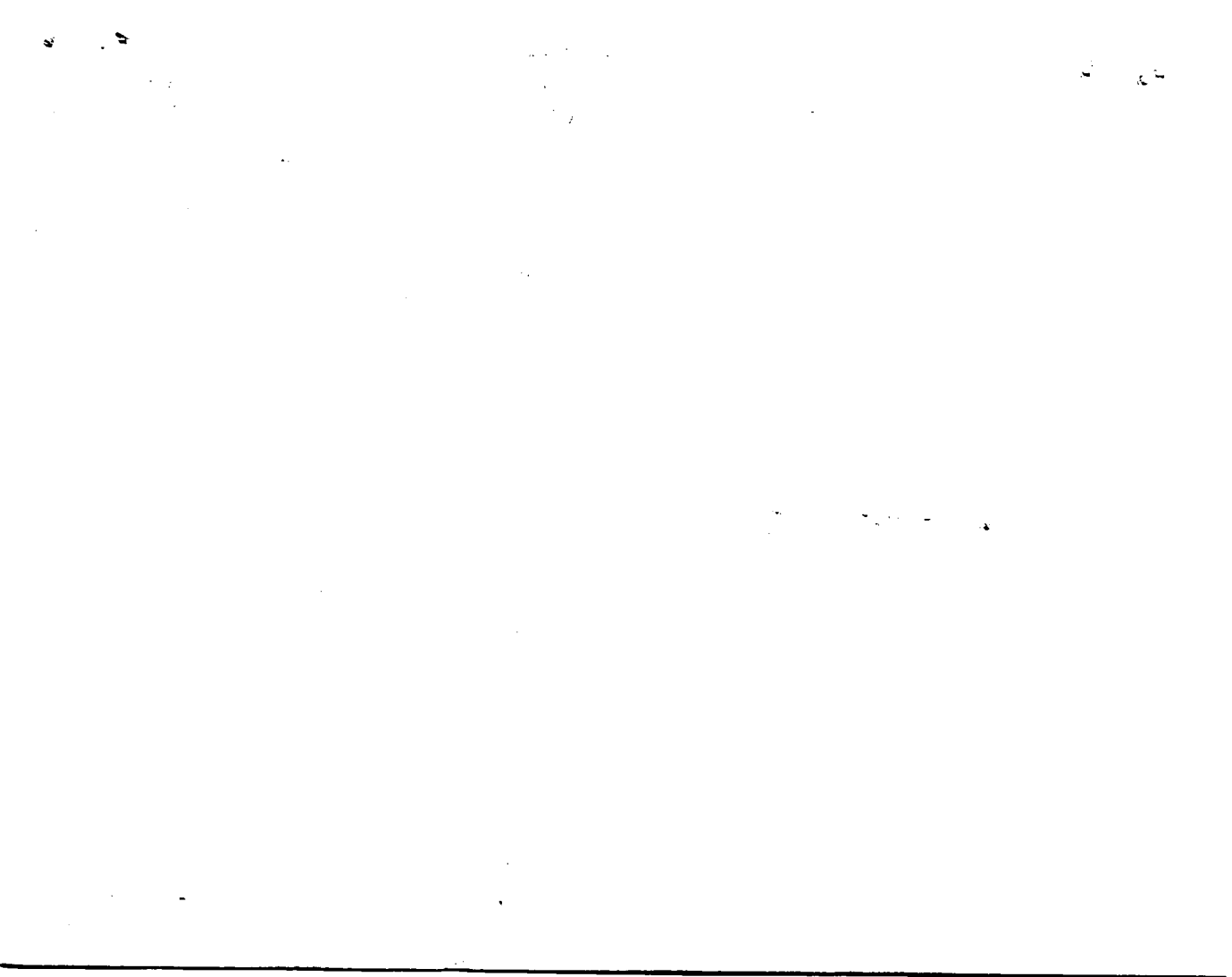
Registrar.

Address \_\_\_\_\_

Filed \_\_\_\_\_

(Physician or midwife)

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED  
JUN 9 1921  
BUREAU OF VITAL STATISTICS

34072

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock  
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Buggeli

Registration District No. 28

Primary Registration District No. 2161

File No. 41

Registered No. 3590

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

f

4. COLOR OR RACE

wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

6. DATE OF BIRTH

5 - 30 1921  
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Francis Fredrick Buggeli

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Gertrude Lilian Cole

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. J. Buggeli

(Address)

2161 Pocatello

15.

Filed

5/31

1921

J. H. Young  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 - 30 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5 - 30 1921 to 5 - 30 1921  
that I last saw him alive on 5 - 30 1921

and that death occurred on the date stated above, at 8:15 A. M.

The CAUSE OF DEATH\* was as follows:

Stillborn dead  
about a week

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Ray  
Pocatello, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pocatello - 2161 - infernal

DATE OF BURIAL

5/31 1921

20. UNDERTAKER

none - (father)

ADDRESS

W. H. Ray

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

913 110-006-497

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Bingham

MAY 20 1921

CERTIFICATE OF BIRTH

City of Blodgett

BUREAU OF VITAL

Registration District No.

121

File No.

90228

No. 4 St.

Primary Registration District No.

1007

Registered No.

125

Hospital

FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and {	Number in order of birth <u>1</u>	Legitimacy? <u>Yes</u>	Date of Birth <u>Apr 10</u> 19 <u>21</u> (Month) (Day) (Year)
--------------------------	---	-------	-----------------------------------	------------------------	--

FATHER  
FULL NAME Geo R. Chumey  
RESIDENCE Blodgett  
COLOR Indian AGE AT LAST BIRTHDAY 22 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Emma Duggie  
RESIDENCE Blodgett, Idaho  
COLOR Indian AGE AT LAST BIRTHDAY 17 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 6. P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. W. McIntosh, M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Blodgett, Idaho

Filed

May 12 1921 Mrs Helen E. Patrice

Registrar

Registrar



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

236-112-010-619

PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF VITAL STATISTICS  
**RECEIVED**  
JUN 13 1921

Form V. S. No. 11-C-25m-7-21-19

County of Bonneville

City of Lona

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

BUREAU OF VITAL  
STATISTICS

Registration District No. 73

File No. \_\_\_\_\_

Primary Registration District No. 2110 Registered No. 101

FULL NAME OF CHILD

Sex of Child Male Twin Triplet 1 and 1 Number in order of birth 1 Legiti mate? yes Date of Birth Feb 12 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Austin Scoresby  
RESIDENCE Lona Ida  
COLOR White AGE AT LAST BIRTHDAY 21 (Years)  
BIRTHPLACE Lona Ida  
OCCUPATION Farmed.

MOTHER  
FULL MAIDEN NAME Rosina Ward  
RESIDENCE Lona  
COLOR White AGE AT LAST BIRTHDAY 20 (Years)  
BIRTHPLACE Lona  
OCCUPATION W. Shop

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born at 10:30 am  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

Address

Filed

Idaho Falls Idaho  
May 10 1921 W. J. Ward  
Registrar

Registrar



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

193-1041010-299

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Bonneville

City of Idaho Falls

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

RECEIVED CERTIFICATE OF BIRTH

Registration District No. 73

File No. 90390

Primary Registration District No. 2150

Registered No. 41

Sex of Child male { Twin Triplet or other? } and { Number in order of birth } Legiti mate? yes Date of Birth April 7 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Harold Miller  
RESIDENCE Idaho Falls, Idaho  
COLOR white AGE AT LAST BIRTHDAY 25 (Years)  
BIRTHPLACE Montana  
OCCUPATION Butcher

MOTHER  
FULL MAIDEN NAME Hallie Brushin  
RESIDENCE Idaho Falls, Idaho  
COLOR white AGE AT LAST BIRTHDAY 28 (Years)  
BIRTHPLACE Montana  
OCCUPATION Housewife

Number of child of this mother, including present birth. / Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

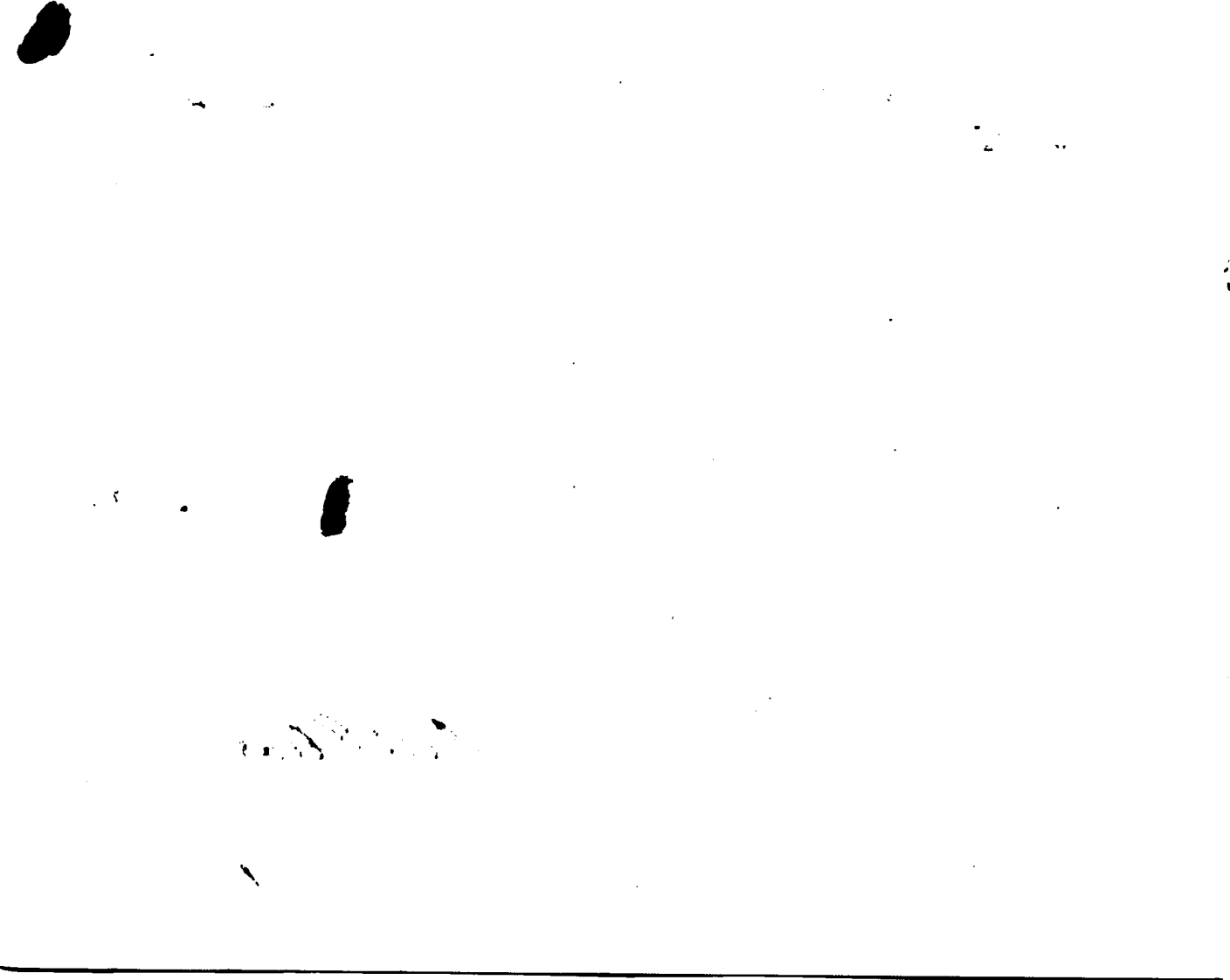
I hereby certify that I attended the birth of this child, who was Stillborn, at 5 A. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Miller  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Idaho Falls, Idaho  
Filed Apr. 16 1921 W. K. ...  
Registrar



## 1. PLACE OF DEATH

County of *Bozemann* Registration District No. *73*  
 City of *Idaho Falls* Primary Registration District No. *2150*  
 City of *Idaho Falls* *Corner Ave.* - 3t.) - Registered No. *38019*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Infant Miller*

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. *38019*Registered No. *38019*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*  
 (Write the word.)

## 6. DATE OF BIRTH

*Apr. 14 1921*  
 (Month) (Day) (Year)

## 7. AGE

*Born dead.* IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

*no*

## 9. BIRTHPLACE

(State or Country)

*Idaho Falls Ida.*

## 10. NAME OF FATHER

*Harold A Miller*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*mont*

## 12. MAIDEN NAME OF MOTHER

*Hallie Brisbin*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*mont*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Harold A Miller*  
*Idaho Falls Ida.*

## 15.

Filed

*July 12 1921*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Apr. 4 1921*  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19\_\_\_\_, to 19\_\_\_\_  
 that I last saw h\_\_\_\_\_ alive on 19\_\_\_\_  
 and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
 (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

*Edith Miller*

M. D.

19\_\_\_\_

(Address)

*Idaho Falls*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Rose Hill Burial*

## DATE OF BURIAL

*Apr. 5 1921*

## 20. UNDERTAKER

*Chaffetz*

## ADDRESS

*Idaho Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



168-201-016-491

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of CassiaCity of Burley

No. \_\_\_\_\_

St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Primary Registration District No. 2196

File No. \_\_\_\_\_

Registered No. 1937Sex of Child FTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate? yesDate of  
Birth Apr 11921

(To be answered only in event of plural births)

(Month) (Day) (Year)

FULL  
NAME

FATHER

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR Bl.AGE AT LAST  
BIRTHDAY 21

(Years)

COLOR Bl.AGE AT LAST  
BIRTHDAY 20

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn,  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

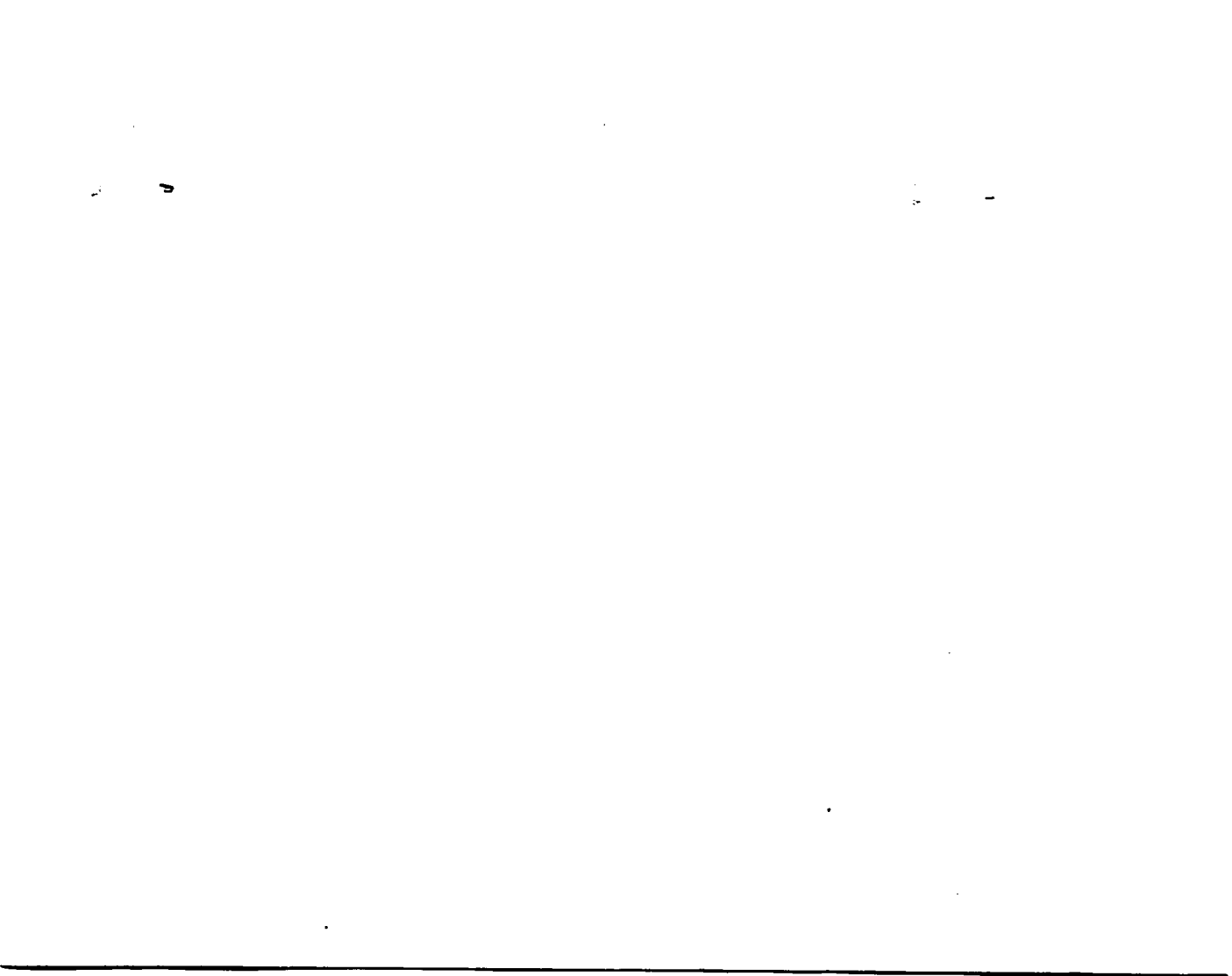
Address

Filed

1921

Registrar

Registrar



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 34184  
Registered No. 495  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of *Cassia* Registration District No. *117*  
City of *Burley* Registration District No. *2196*  
If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Stillborn*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

## 6. DATE OF BIRTH.

*Apr 1 1921*  
Month Day Year

## 7. AGE

*Stillborn*

IF LESS than 1 day  
how many hrs. or  
Yrs. Mos. ds. min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*Stillborn*

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*B. F. Johansen*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Nebraska*

## 12. MAIDEN NAME OF MOTHER

*Martha Draper*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Utah*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*B. F. Johansen*  
*Burley, Ida.*

## 15.

Filed *Apr 8* 191*21* *Dr. J. C. Patterson*  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Stillborn* 191.....  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

191..... to 191.....

that I last saw him alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *J. C. Patterson* M. D.

4-1-1921.. (Address) *Burley, Ida.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Burley Ida*

## DATE OF BURIAL

*Apr 1* 191*21*

## 20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

28-1090145419

PLACE OF BIRTH.

Form V. S. No. 11-C-25m-7-21-19

County of Carson RECEIVED STATE OF IDAHO  
JUN 13 1921 BUREAU OF VITAL STATISTICS  
City of Melba BUREAU OF VITAL STATISTICS  
No. \_\_\_\_\_ St. \_\_\_\_\_ File No. 90483  
Hospital \_\_\_\_\_ Primary Registration District No. 2006 Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Sex of Child Male Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legiti mate? Yes Date of Birth May 9 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Lester See Sharp  
RESIDENCE Melba, Id.  
COLOR White AGE AT LAST BIRTHDAY 43 (Years)  
BIRTHPLACE Iowa  
OCCUPATION Asst. Water Master

MOTHER  
FULL MAIDEN NAME Lulu Core Marquis  
RESIDENCE Melba, Id.  
COLOR White AGE AT LAST BIRTHDAY 40 (Years)  
BIRTHPLACE Iowa  
OCCUPATION House Wife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 9 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Sammell Swaine  
(Physician or midwife)

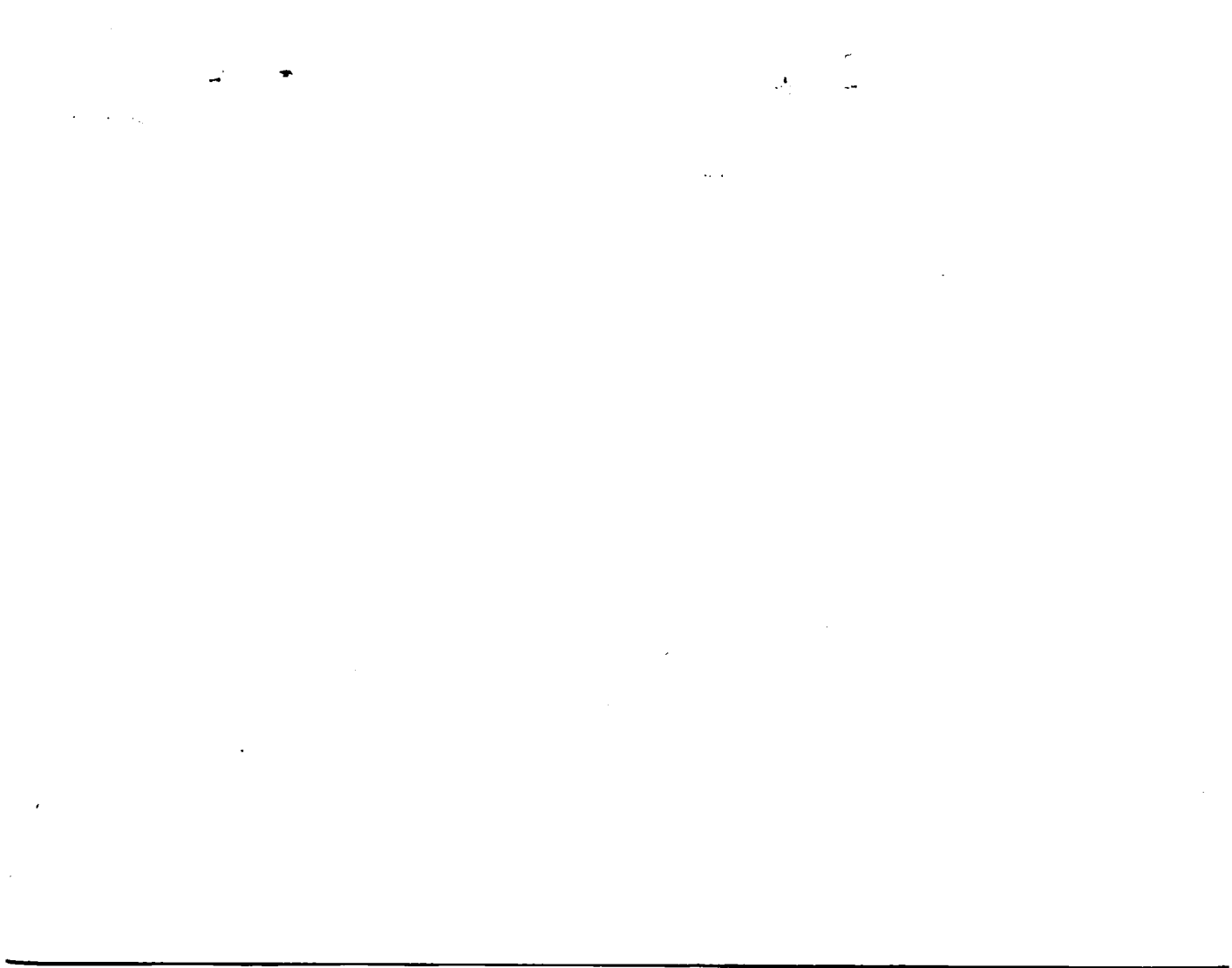
Given names added from a supplemental report.

19

Address \_\_\_\_\_

Registrar

Filed June 10 1921 Pearle Dodds  
Registrar



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

Registration District No. \_\_\_\_\_  
 County of Canyon RECEIVED  
 Primary Registration District No. 2066  
 City of Melba JUN 13 1921  
 (St.) \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## BUREAU OF VITAL STATISTICS

## 2. FULL NAME

Baby Sharp

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 34169  
 Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single  
 (Write the word.)

## 6. DATE OF BIRTH

May 9 1921  
 (Month) (Day) (Year)

## 7. AGE

0 Yrs. 0 Mos. 0 ds.  
 IF LESS than 1 day  
 how many 0 hrs.  
 or 0 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

none

## 9. BIRTHPLACE

(State or Country)

Canyon Co, Id.

## 10. NAME OF FATHER

Lester Lee Sharp

## 11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

## 12. MAIDEN NAME OF MOTHER

Lula Core Morgan

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lester Lee Sharp

(Address)

## 15.

Filed June 12 1921 Pearle Dodds  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 9 1921  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

May 9, 1921, to May 9, 1921  
 that I last saw him alive on May 9, 1921

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:

Still born.Pre-maturity - 6 mo. gestation

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory  
 (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

Samuel A. Swayze, D.19

(Address)

Melba, Id.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Melba

## DATE OF BURIAL

June 10, 1921

## 20. UNDERTAKER

none

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

665-205-021-753

PLACE OF BIRTH

County of Franklin

City of Preston Star Route

No. .... St.

Hospital .....

FULL NAME OF CHILD Elda May

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-28m-9-8-17

RECEIVED  
JUN 11 1921  
BUREAU OF VITAL STATISTICS  
Primary Registration District No. 27

Registration District No. 2119 File No. 90574

Registered No. 133

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> { Number in order of birth	Legitimate? <u>Yes</u>	Date of Birth <u>May 5</u> (Month) (Day) (Year) <u>1921</u>
----------------------------	--	------------------------	--

FATHER  
FULL NAME Ernest Owens  
RESIDENCE Preston R. - 1  
COLOR White AGE AT LAST BIRTHDAY 38 (Years)  
BIRTHPLACE England  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Matilda Peterson  
RESIDENCE Preston R. - 1  
COLOR White AGE AT LAST BIRTHDAY 35 (Years)  
BIRTHPLACE Ovid, Bear Lake Co., Ida.  
OCCUPATION Housewife

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Dead at 4 A.M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) G. W. States  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Preston Ida.  
Filed May 31 1921  
Registrar D. R. Cuervo

Gr

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

666411-021-769

PLACE OF BIRTH

County of... FranklinCity of... FranklinNo. .... St.

Hospital .....

FULL NAME OF CHILD .....

RECEIVED  
JUN 11 1921  
BUREAU OF VITAL  
STATISTICS

Registration District No. .... 2119Primary Registration District No. .... 21

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-24m-9-3-17

File No. .... 90577Registered No. .... 134

Sex of Child <u>male.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes.</u>	Date of Birth <u>May 11</u> 19 <u>21</u> (Month) (Day) (Year)
---------------------------	---	--------------------------------------	------------------------------	---

FATHER		MOTHER	
FULL NAME <u>Garnet Woodward,</u>	FULL MAIDEN NAME <u>Alice Porter</u>	FULL NAME <u>Alice Porter</u>	FULL MAIDEN NAME <u>Alice Porter</u>
RESIDENCE <u>Franklin</u>	RESIDENCE <u>Franklin</u>	RESIDENCE <u>Franklin</u>	RESIDENCE <u>Franklin</u>
COLOR <u>White.</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)	COLOR <u>White.</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Franklin Ida.</u>	BIRTHPLACE <u>Escalante Utah.</u>	BIRTHPLACE <u>Escalante Utah.</u>	BIRTHPLACE <u>Escalante Utah.</u>
OCCUPATION <u>Farmer.</u>	OCCUPATION <u>Housewife.</u>	OCCUPATION <u>Housewife.</u>	OCCUPATION <u>Housewife.</u>

Number of child of this mother, including present birth... 4 ... Number of children of this mother now living, including present birth... 1 ...

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn. at 3. P. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) .... G. W. States ....

Physician

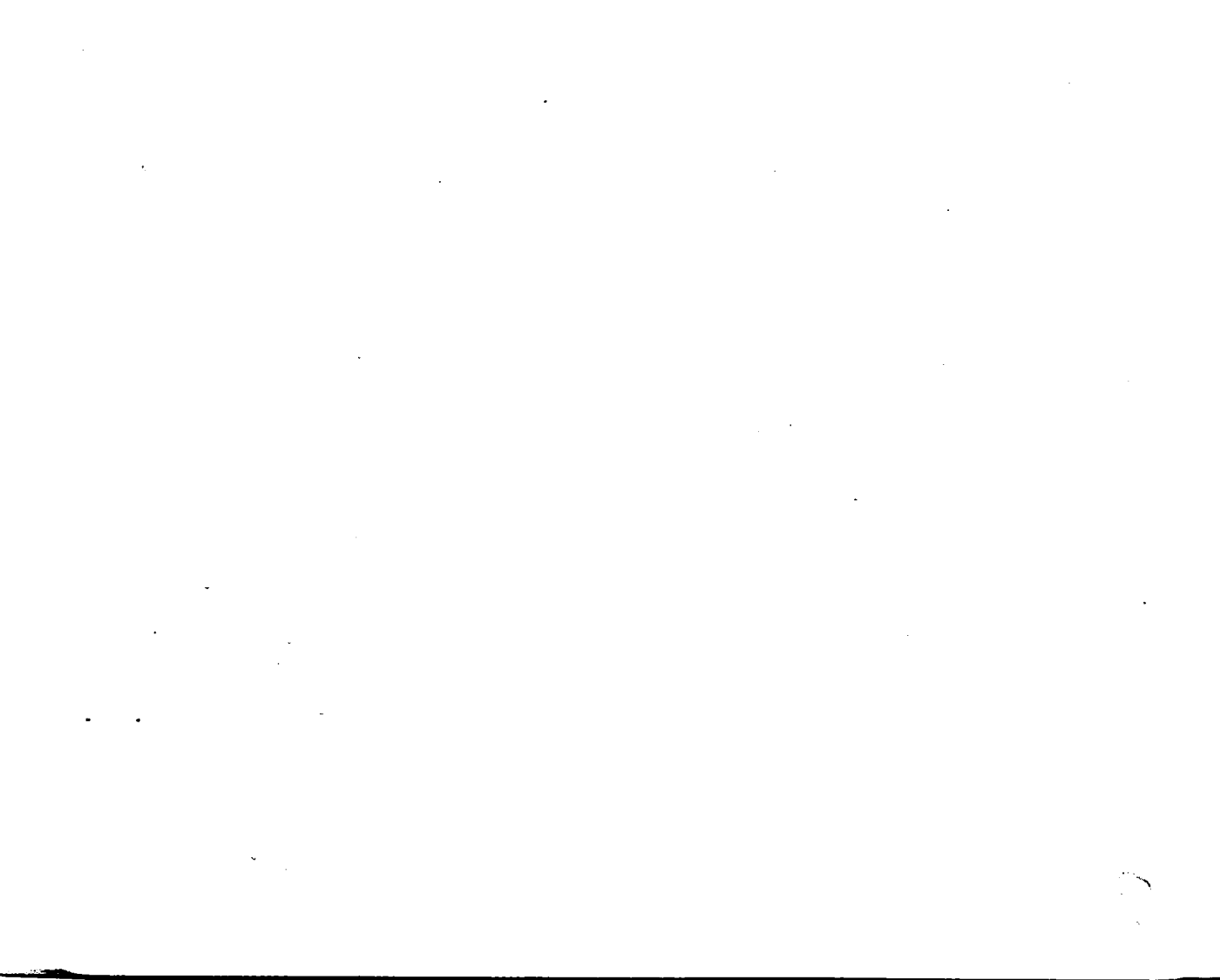
(Physician or midwife)

Given names added from a supplemental report.

Address .... Preston Ida. ....Filed May 31 1921 D. A. R. Cullen

Registrar

Registrar



366-222-021-535  
 PLACE OF BIRTH

STATE OF IDAHO  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-9-3-37

County of Franklin

City of Franklin

No. St.

Hospital .....

Registration District No. 2119  
 Primary Registration District No. 27

File No. 90581

Registered No. 138

FULL NAME OF CHILD .....

Sex of Child <u>Female</u>	Twin Triplet or other? <u>.....</u> and { Number in order of birth <u>.....</u>	Legitimate? <u>Yes</u>	Date of Birth <u>May 22</u> 191 <u>21</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

FATHER  
 FULL NAME Gilbert Lowe  
 RESIDENCE Franklin  
 COLOR White AGE AT LAST BIRTHDAY 21 (Years)  
 BIRTHPLACE Franklin  
 OCCUPATION Farmer

MOTHER  
 FULL MAIDEN NAME Leone Stephenson  
 RESIDENCE Franklin  
 COLOR White AGE AT LAST BIRTHDAY 22 (Years)  
 BIRTHPLACE Lewiston Utah  
 OCCUPATION Housewife

Number of child of this mother, including present birth 1..... Number of children of this mother now living, including present birth .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 10:45 A.M. on the date above stated.  
 (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) G. W. States  
Physician  
 (Physician or midwife)

Given names added from a supplemental report.

Address Preston Ida.

Filed May 31 1921  
S. C. Cullis  
 Registrar



319-115014-955

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

County of \_\_\_\_\_

City of \_\_\_\_\_

No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

RECEIVED  
JUN 13 1921  
BUREAU OF VITAL  
STATISTICSRegistration District No. 3

File No. \_\_\_\_\_

Primary Registration District No. 2007Registered No. 84Baby Carlson

Sex of Child <u>M</u>	Twin <input checked="" type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input type="checkbox"/>	and	Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>Jan 15</u> 19 <u>21</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

FULL NAME <u>Olof Carlson</u>	FATHER
RESIDENCE <u>Panna</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Sweden</u>	
OCCUPATION <u>Farming</u>	

FULL MAIDEN NAME <u>Emma Rupp</u>	MOTHER
RESIDENCE <u>Panna, Ida.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Joseph, Ore.</u>	
OCCUPATION <u>House wife</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born, at 10 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. Hunter

(Physician or midwife)

Given names added from a supplemental report.

19. \_\_\_\_\_

Address Panna Ida.Filed 6-11921

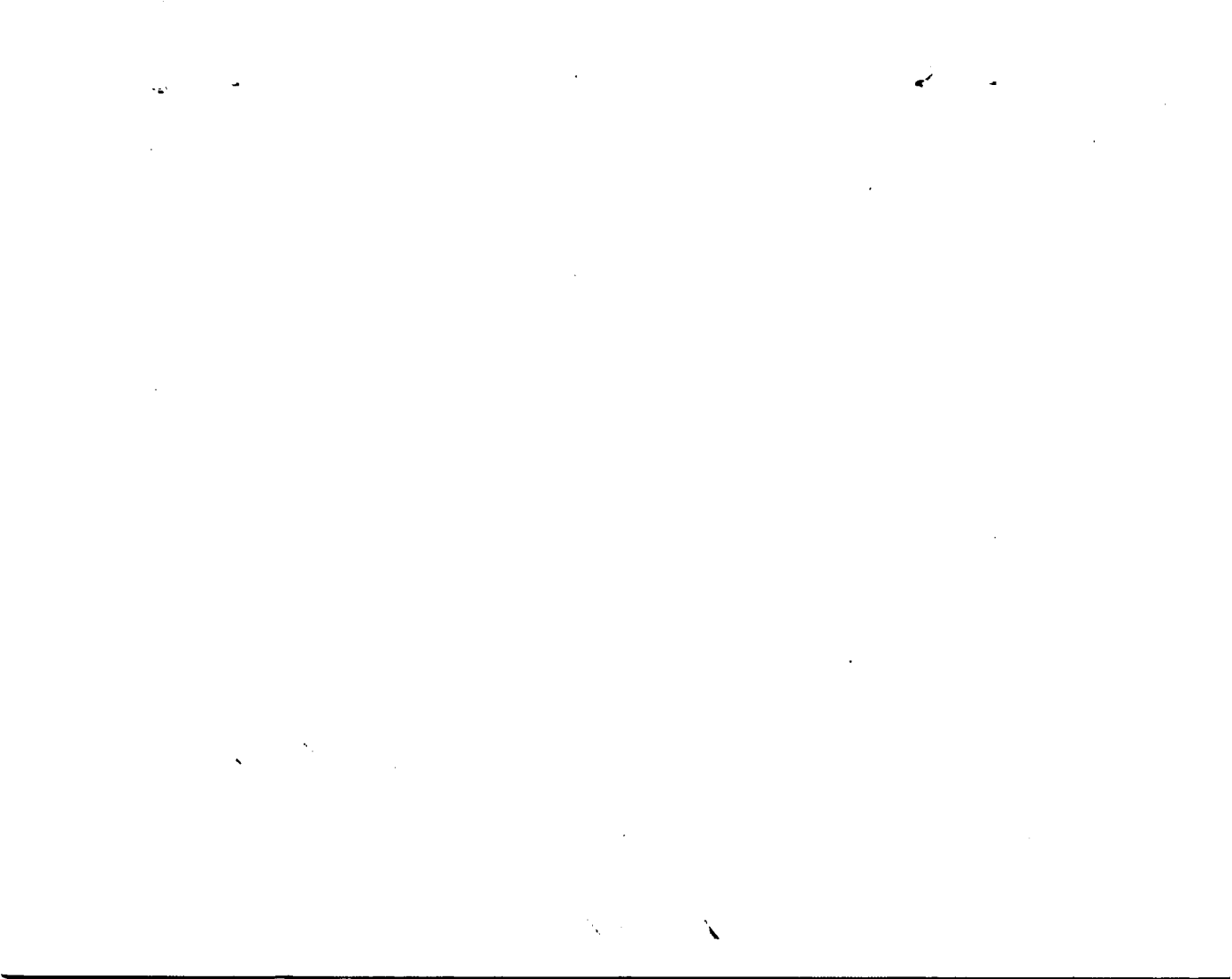
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.





FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

County of Canyon  
City of ParmaRegistration District No. 2Primary Registration District No. 2007

(No. .... St.)

File No. 32842Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Emma Carlsson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.

(Write the word.)

## 6. DATE OF BIRTH.

Jan 15 1921  
(Month) (Day) (Year)

## 7. AGE

..... Yrs. .... Mos. 4 8IF LESS than 1 day  
how many ..... hrs. or  
..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country) Canyon Co

## 10. NAME OF FATHER

Olof Carlsson

## 11. BIRTHPLACE OF FATHER

(State or Country) Sweden

## 12. MAIDEN NAME OF MOTHER

Emma G Roup

## 13. BIRTHPLACE OF MOTHER

(State or Country) Concepcion

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Olof Carlsson(Address) Parma Ida

## 15.

Filed Jan 17 1921Richard J. ...  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Jan 15 1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased ~~from~~  
Jan 15 1921 for 1 hour 191  
that I last saw him ~~alive~~ on Jan 15 1921  
and that death occurred on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH\* was as follows:

Still Birth, at 6 2/3  
months.

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... Yrs. .... mos. .... ds.

(Signed) Wm S. ... M. D.19. (Address) Parma, Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Roswell IdaJan 17 1921

## 20. UNDERTAKER

## ADDRESS

Beckham Fin CoParma

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

1891  
cc

235-110-025-413  
PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-8-15

Country of Idaho RECEIVED  
City of Stites JUN 14 1921  
No. 106 BUREAU OF VITAL STATISTICS  
Primary Registration District No. 2184 File No. 90642  
Registered No. 10

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of Birth <u>May 10 1921</u> (Month) (Day) (Year)
FULL NAME <u>Gilbert Arthur Blewett</u>	FATHER	FULL MAIDEN NAME <u>Elizabeth Wales</u>	MOTHER	
RESIDENCE <u>Near Stites</u>		RESIDENCE <u>Near Stites</u>		
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	
BIRTHPLACE <u>Nebraska</u>		BIRTHPLACE <u>Missouri</u>		
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>		

Number of child of this mother, including present birth One

Number of children of this mother now living, including present birth none

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

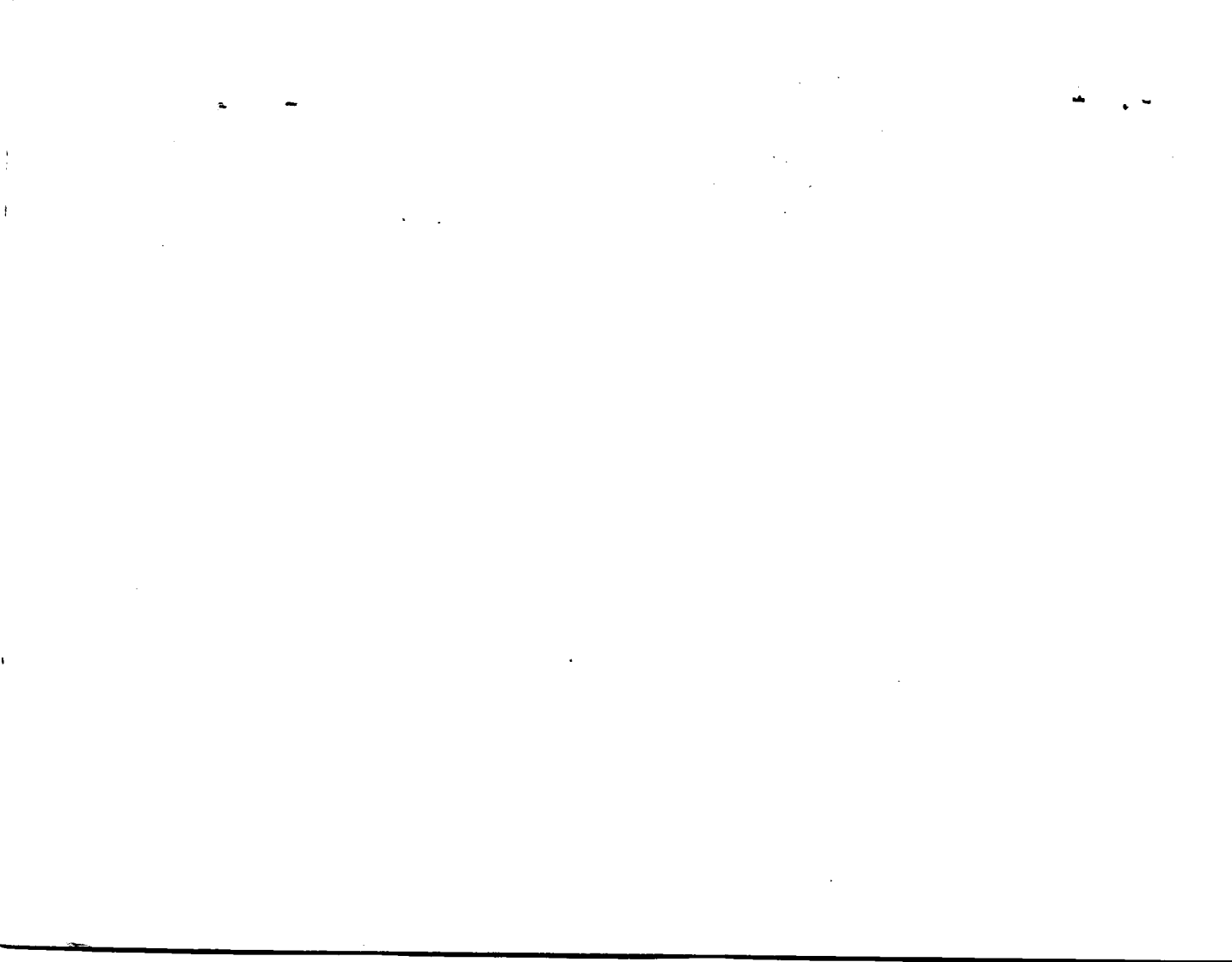
I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Stillborn at 11 A M.  
(born alive or stillborn)  
(Signature) H. W. Wentworth M.D.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Physician or midwife)  
Address Stites Ida  
Filed June 1 1921 James Wentworth  
Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Idaho Registration District No. 106  
 City of Stites Registration District No. 2184 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 34222  
 Registered No. 110

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

May 1921  
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
 how many, .... hrs. or  
 .... min.

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Gilbert Renton Blewett

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Elizabeth Wales

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Gilbert R. Blewett

(Address)

Stites Ida

15.

Filed May 12 1921

J. M. Baker  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 10th 1921  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191  
 that I last saw h. — alive on — 191

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH was as follows:

Violent labor - Born dead

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Forceps

(Duration) Yrs. mos. ds.

(Signed)

H. W. W. W. W. W.May 12 1921 (Address) Stites Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baile Ridge CemeteryMay 10 1921

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

419-102-026-431  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED

MAY 20 1921

## BUREAU OF VITAL

## STATISTICS

## CERTIFICATE OF BIRTH

90684

County of JeffersonCity of Rigby

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 98

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2176Registered No. 77

## FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>M</u>	Twin Triplet or other? <u>( )</u> and { Number in order of birth <u>( )</u>	Legitimate? <u>Yes</u>	Date of Birth <u>May 2</u> 19 <u>21</u> (Month) (Day) (Year)
-----------------------	---	------------------------	---

FULL NAME <u>Wm. Thos. Mains</u>	FATHER
RESIDENCE <u>Rigby</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Kentucky</u>	
OCCUPATION <u>Electrician</u>	

FULL MAIDEN NAME <u>Edith McArthur</u>	MOTHER
RESIDENCE <u>Rigby</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Stillborn at 9 P. M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

(Physician or midwife)

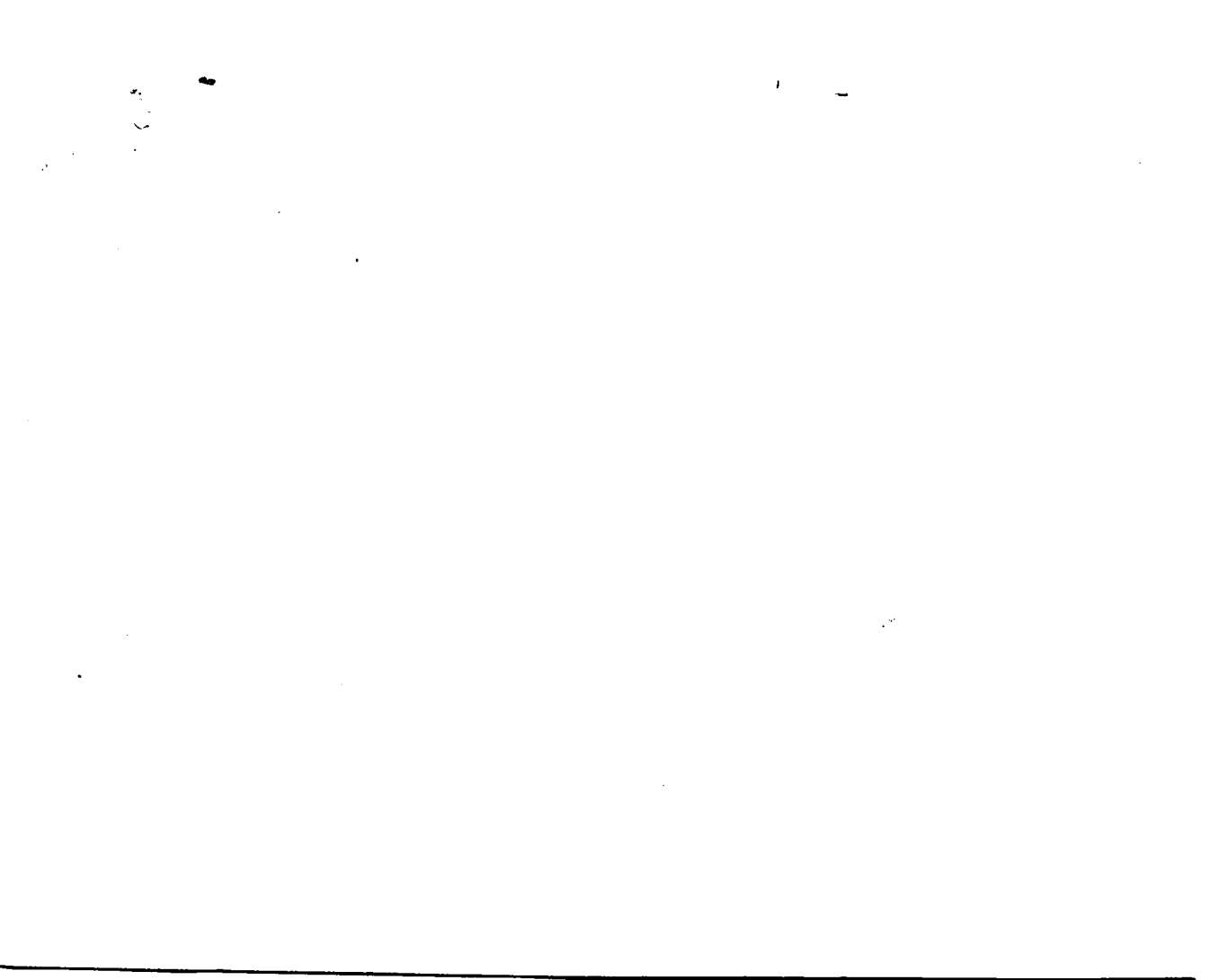
Given names added from a supplemental report. \_\_\_\_\_

Address \_\_\_\_\_

Filed \_\_\_\_\_

Registrar. \_\_\_\_\_

Registrar. \_\_\_\_\_





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Jefferson Registration District No. \_\_\_\_\_  
City of \_\_\_\_\_ Registration District No. \_\_\_\_\_  
St.) \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

**RECEIVED**  
**MAY 20 1921**  
**BUREAU OF VITAL STATISTICS**

Stillborn

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 34240

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Born  
(Write the word.)

6. DATE OF BIRTH.

May 2 1921  
(Month) (Day) (Year)

7. AGE

Stillborn

IF LESS than 1 day  
how many \_\_\_\_\_ hrs. or  
\_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm P. Mairis

11. BIRTHPLACE OF FATHER

(State or Country)

Ken.

12. MAIDEN NAME OF MOTHER

Edith Mae Arthur

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Wm P. Mairis  
Regley, Ida

15.

Filed

May 10 1921  
Ray H. Fink  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 2 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191\_\_\_\_, to 191\_\_\_\_,

that I last saw h\_\_\_\_\_ alive on 191\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn, Premature  
Placenta previa  
(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

May 3 1921 (Address) Regley, Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Regley, Ida May 3 1921  
20. UNDERTAKER Friends ADDRESS Regley, Ida

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

713-129-026-469

PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICSRECEIVED  
MAY 20 1921County of Jefferson

CERTIFICATE OF BIRTH

City of Kimberly

BUREAU OF VITAL

STATISTICS

Registration District No. 98File No. 90685

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2176Registered No. 80

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>m</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>1-29-21</u> (Month) (Day) (Year)
-----------------------	---	-----------	--------------------------------	------------------------	--

FULL NAME <u>Amos E. L. Gallup</u>	FATHER	FULL MAIDEN NAME <u>Lola G. Morgan</u>	MOTHER
------------------------------------	--------	--	--------

RESIDENCE <u>Antelope</u>	RESIDENCE <u>Antelope</u>
---------------------------	---------------------------

COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
----------------	---	----------------	---

BIRTHPLACE <u>Utah</u>	BIRTHPLACE <u>Idaho</u>
------------------------	-------------------------

OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>
--------------------------	-----------------------------

Number of child of this mother, including present birth <u>5</u>	Number of children of this mother now living, including present birth <u>3</u>
--	--

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn 4 A M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Sam J. Price

(Physician or midwife)

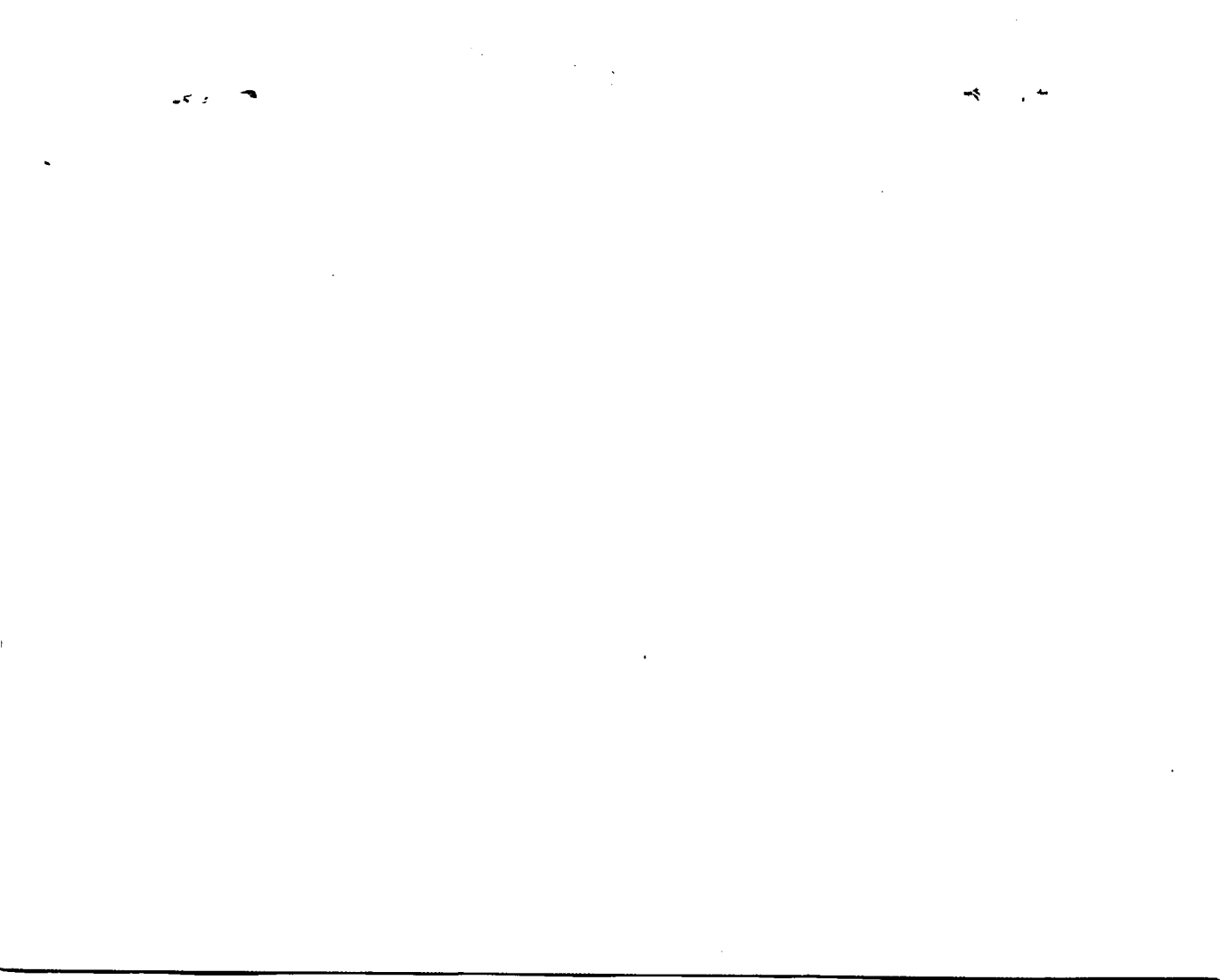
Given names added from a supplemental report.

19

Address KimberlyFiled 5/10 21 19

Registrar.

Registrar.



FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

Registration District No.

May 20 1921

BUREAU OF VITAL

STATES

## 2. FULL NAME

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

## 6. DATE OF BIRTH

## 7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month)

(Day)

19 (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Duration)

yrs.

mos.

ds.

1/30 1921

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

462-105-026 ✓ 41  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

RECEIVED BUREAU OF VITAL STATISTICS

County of Jefferson MAY 20 1921 CERTIFICATE OF BIRTHCity of Roberts BUREAU OF VITAL STATISTICSRegistration District No. 98File No. S-90702

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2176 Registered No. 123

Hospital \_\_\_\_\_

FULL NAME OF CHILD MossSex of Child M Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legitimate? yes Date of Birth 4-5-21  
(Month) (Day) (Year)FULL NAME FATHER Charles Edmond Moss FULL MAIDEN NAME MOTHER Myrtle M AdamsRESIDENCE Roberts RESIDENCE RobertsCOLOR W AGE AT LAST BIRTHDAY 35 (Years) COLOR W AGE AT LAST BIRTHDAY 23 (Years)BIRTHPLACE Utah BIRTHPLACE Ida.OCCUPATION Rancher OCCUPATION HousewifeNumber of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 7<sup>45</sup> A.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Earl D. Jones

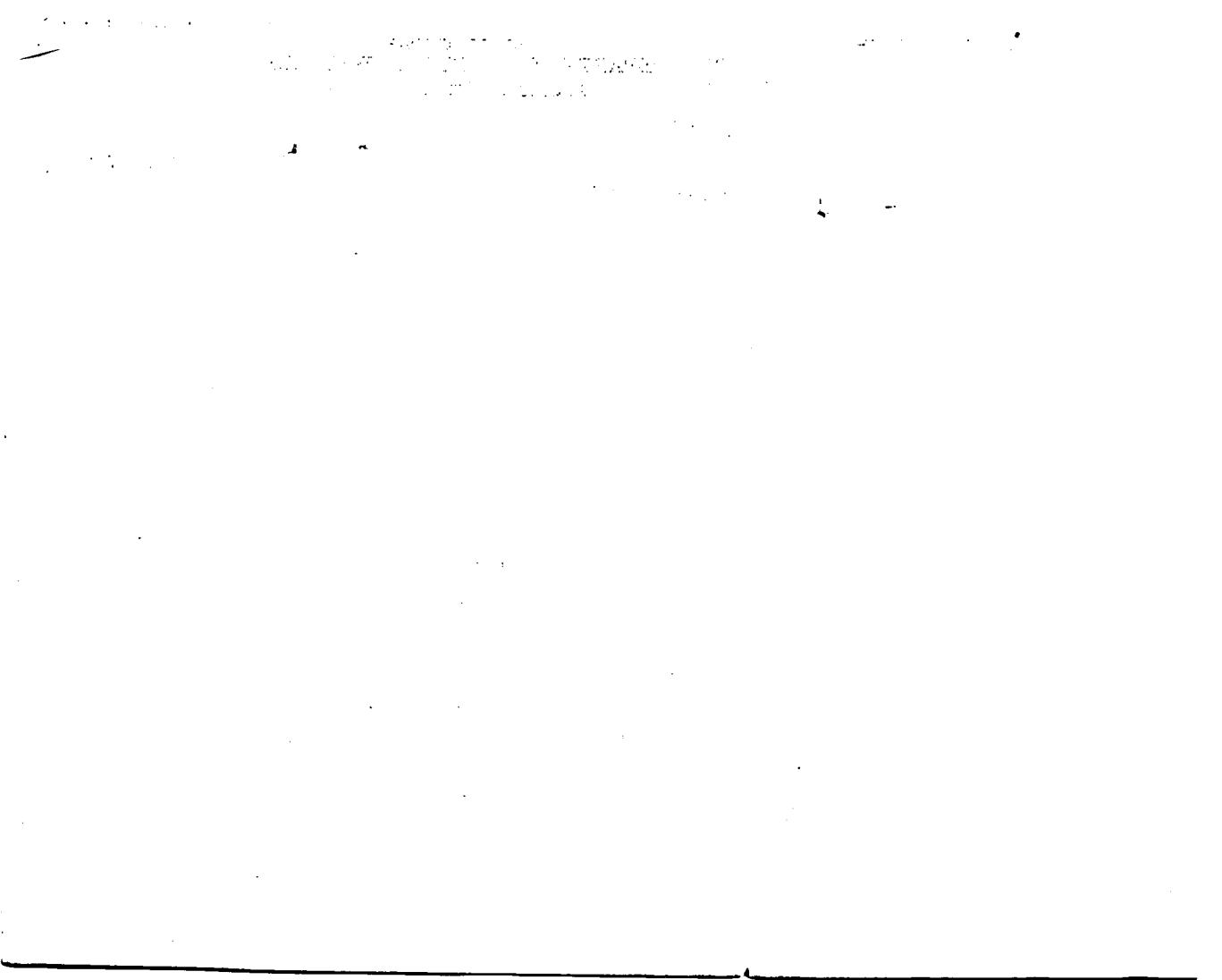
(Physician or midwife)

Given names added from a supplemental report.

Address RobertsFiled 5710 21 Ray H Fisher

Registrar.

Registrar.





## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED  
(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

RECEIVED

Registration District No.

MAY 20 1921

BUREAU OF VITAL STATISTICS

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19.

to

19.

that I last saw him alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

(Duration)

Yrs.

mos.

ds.

Apr 6 1921

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

552-123-027-285-  
PLACE OF BIRTH

Form V. S. No. 11--20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED

MAY 27 1921

CERTIFICATE OF BIRTH

90774

County of Jerome

City of Jerome

BUREAU OF VITAL  
STATISTICS

Registration District No. 23

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2017

Registered No. \_\_\_\_\_

Hospital Home

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and <u>other</u>	Number in order of birth <u>1st</u>	Legiti- mate? <u>yes</u>	Date of Birth <u>4/23</u> (Month) (Day) (Year) <u>1921</u>
-----------------------	---	------------------	--	--------------------------------	---

FATHER  
FULL NAME Hiram Mead West

RESIDENCE Jerome

COLOR W AGE AT LAST BIRTHDAY 21  
(Years)

BIRTHPLACE Utah

OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Anrilla Shepherd

RESIDENCE Jerome

COLOR W AGE AT LAST BIRTHDAY 18  
(Years)

BIRTHPLACE Utah

OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 7 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. P. Zeller  
M. D.  
(Physician or midwife)

Given names added from a supplemental report. \_\_\_\_\_

Address Jerome Idaho

Filed May 26 1921 E. D. Piper M. D.  
Registrar. Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

Dr

433-123-028-418

PLACE OF BIRTH

County of *Kootenai*City of *Spirit Lake, Ida.*

No. .... St.

Hospital .....

FULL NAME OF CHILD *Stillborn 7 1/2 mo.*

RECEIVED

MAY 28 1921

BUREAU OF VITAL  
STATISTICSSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTHFile No. *90811*

Registered No. ....

Primary Registration District No. ....

Sex of Child <i>Male</i>	Twin Triplet or other? <i>1</i>	and { Number in order of birth (To be answered only in event of plural births) <i>-</i>	Legiti- mate? <i>yes</i>	Date of Birth <i>6-23</i> (Month) (Day) (Year) <i>1921</i>
--------------------------	---------------------------------------	--	-----------------------------	--

FULL NAME <i>Albert W. Clardy</i>	FATHER
RESIDENCE <i>Spirit Lake, Ida.</i>	
COLOR <i>Wh.</i>	AGE AT LAST BIRTHDAY <i>34</i> (Years)
BIRTHPLACE <i>Cal.</i>	
OCCUPATION <i>R. R. Broker</i>	

FULL MAIDEN NAME <i>Paul Day</i>	MOTHER
RESIDENCE <i>Spirit Lake, Ida.</i>	
COLOR <i>Wh.</i>	AGE AT LAST BIRTHDAY <i>22</i> (Years)
BIRTHPLACE <i>N. Carolina</i>	
OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth *4*..... Number of children of this mother now living, including present birth *3*.....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was *Stillborn* at *9 A.* M. on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *Earl J. Smith*

(Physician or midwife)

Given names added from a supplemental report.

Address.....

Filed *Nov 21* 19*21*

Registrar

Registrar

*Uterine Compression at 7 1/2 mo - Induced labor - shoulder presentation  
Manual dilatation cervix - version - dead fetus - esp*



556-206-035-415

BIRTH

STATE OF IDAHO

Form V. S. No. 11-C—25m-9-8-15

BUREAU OF VITAL STATISTICS

RECEIVED

MAY 20 1921

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of

City of

No.

St.

Primary Registration District No.

File No.

Registered No.

90853

FULL NAME OF CHILD

Sex of Child

Female

Twin  
Triplet  
or other?

{ and }

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti-  
mate?Date of  
Birth

(Month)

(Day)

(Year)

FULL  
NAMEFATHER  
Clarence A. Newman

RESIDENCE

Ney Peres Co

COLOR

white

AGE AT LAST  
BIRTHDAY31  
(Years)

BIRTHPLACE

Wash

OCCUPATION

Farmer

FULL  
MAIDEN  
NAMEMOTHER  
Mamie Davis

RESIDENCE

Ney Peres Co

COLOR

white

AGE AT LAST  
BIRTHDAY24  
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

Number of child of this mother, including present birth

2

Number of children of this mother now living, including present birth

1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

Stillborn

(Born alive or stillborn)

at 2-P M.

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

W. A. Rothwell M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address

Filed

Kendrick Idaho  
Apr. 7 1921 R. F. Pepper

Registrar

Registrar





WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

1. PLACE OF DEATH.

County of *Hayden*

City of *Idaho*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED  
MAY 24 1921  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *68*

Primary Registration District No. *no name*

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. *34322*

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Female*

4. COLOR OR RACE

*white*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*single*  
(Write the word.)

6. DATE OF BIRTH

*April 6th 1921*  
(Month) (Day) (Year)

7. AGE

*Stillborn*  
yrs. mos. da.

IF LESS than 1 day  
how many hrs. or min.)

8. OCCUPATION

- (a) Trade, profession or particular kind of work  
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*Clarence A. Newman*

11. BIRTHPLACE OF FATHER

(State or Country)

*Wash -*

12. MAIDEN NAME OF MOTHER

*Mamie Davis*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*W. A. Rothwell M.D.*

(Address)

*Kendrick Idaho*

15.

Filed

*Apr. 7 1921*

*R. F. Pepple*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*April 6th 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*W. A. Rothwell M. D.*

*April 7 1921* (Address) *Kendrick Idaho*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. In the State. yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Kendrick Cemetery*

*Apr. 7th 1921*

20. UNDERTAKER

*E. E. Bechtel*

ADDRESS

*Kendrick Idaho*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 22 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

231-106.033-753

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

RECEIVED

## CERTIFICATE OF BIRTH

JUN 9 1921

County of MadisonCity of RibbingRegistration 100File No. 90884No. - St. -BUREAU OF VITAL  
STATISTICSPrimary Registration District No. 2178Registered No. -Hospital -

## FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? <u>-</u> and <u>-</u> Number in order of birth <u>-</u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of Birth <u>5-6-21</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

FULL NAME FATHER Josiah BlackburnRESIDENCE RibbingCOLOR White AGE AT LAST BIRTHDAY 36  
(Years)BIRTHPLACE UtahOCCUPATION Stone MasonFULL MAIDEN NAME MOTHER Eliza A. PeckRESIDENCE RibbingCOLOR White AGE AT LAST BIRTHDAY 31  
(Years)BIRTHPLACE UtahOCCUPATION HousewifeNumber of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 4

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:30 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Lorine T. Rich

(Physician or midwife)

Given names added from a supplemental report.

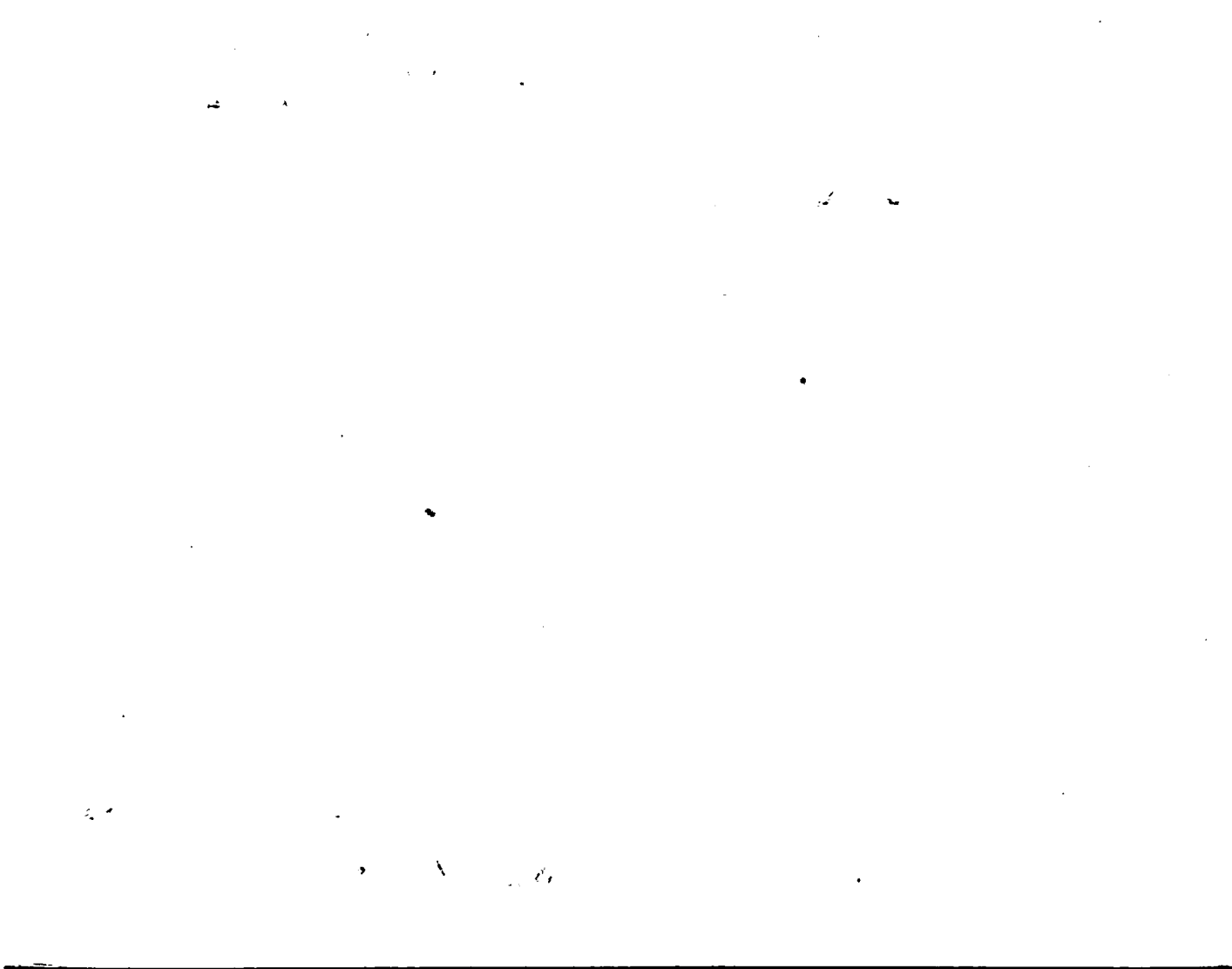
19Address RibbingFiled June 6 1921

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 34291

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of .....

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ...., ..... St.)

## 2. FULL NAME Baby Blackburn

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Male

(Write the word.)

6. DATE OF BIRTH

May 6 1921  
(Month) (Day) (Year)

7. AGE

Yrs. .... Mos. .... ds.

IF LESS than 1 day  
how many .... hrs. or  
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Balcon

9. BIRTHPLACE

(State or Country)

Rushburg

10. NAME OF FATHER Josiah Blackburn

11. BIRTHPLACE OF FATHER

(State or Country)

Wata

12. MAIDEN NAME OF MOTHER

Eugene A. Peck

13. BIRTHPLACE OF MOTHER

(State or Country)

Wata

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Josiah Blackburn  
Rushburg

15.

Filed 5/7 21 1921

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 6 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-6-21 1921 to 5-6-21 1921

that I last saw him alive on 5-6-21 1921

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) .... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) .... Yrs. .... mos. .... ds.

(Signed) Loring A. Peck M. D.

5/6 1921 (Address) Rushburg

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days In the State .... yrs. .... mos. .... days

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

20. UNDERTAKER

DATE OF BURIAL

5/9 1921

ADDRESS

Casper  
Myung

Rushburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

864-108-033-343  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICSCounty of Madison

JUN 9 1921

## CERTIFICATE OF BIRTH

City of HerbertBUREAU OF VITAL  
STATISTICSRegistration District No. 100File No. 90889

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2178

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of Birth <u>April 8th</u> 19 <u>21</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-----------------------------	---

FATHER  
FULL NAME Mark H. YoungRESIDENCE Archer IdahoCOLOR White AGE AT LAST BIRTHDAY 25  
(Years)BIRTHPLACE Archer IdahoOCCUPATION FarmerMOTHER  
FULL MAIDEN NAME Bertha M. LuthyRESIDENCE Archer IdahoCOLOR White AGE AT LAST BIRTHDAY 21  
(Years)BIRTHPLACE Herbert IdahoOCCUPATION HousewifeNumber of child of this mother, including present birth 2nd Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still Born On Apr 8th 1921 4-40 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Parley NelsonM.D.  
(Physician or ~~midwife~~)

Given names added from a supplemental report. \_\_\_\_\_

Address Rexburg IdahoFiled June 6 1921

Registrar.

Registrar.

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

PLACE OF BIRTH

File No.

Registration District No.

Registered No.

Registration District No.

Date of Birth  
(Month) (Day) (Year)

OTHER

AM



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

351-226-03V-499

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of Minidoka RECEIVED JUN 11 1921

City of Minidoka BUREAU OF VITAL STATISTICS

Registration District No. 19

File No. 90926

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2015 Registered No. 85

Hospital \_\_\_\_\_

FULL NAME OF CHILD Stillborn

Sex of Child <u>Male</u>	Twin <input checked="" type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/>	and	Number in order of birth <u>2</u>	Legitimate? <u>Yes</u>	Date of Birth <u>4</u> <u>26</u> <u>1921</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

FULL NAME Louise Leavitt FATHER  
RESIDENCE Minidoka  
COLOR white AGE AT LAST BIRTHDAY 35  
(Years)  
BIRTHPLACE Utah  
OCCUPATION R.R. Eng.

FULL MAIDEN NAME Bessie Wray MOTHER  
RESIDENCE Minidoka  
COLOR white AGE AT LAST BIRTHDAY 32  
(Years)  
BIRTHPLACE Utah  
OCCUPATION Housewife

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

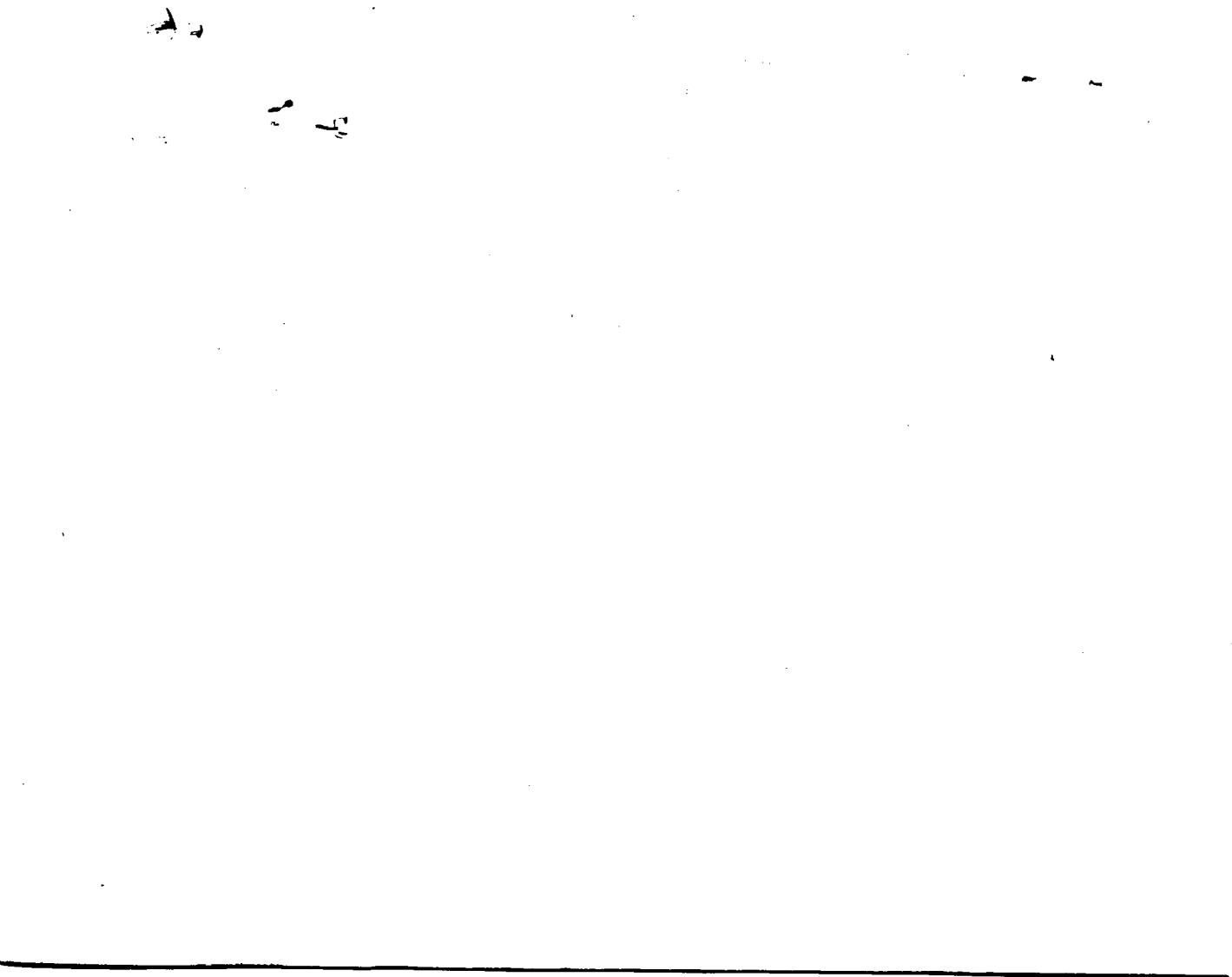
I hereby certify that I attended the birth of this child, who was Stillborn, at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) B. P. Groom  
\_\_\_\_\_  
(Physician or midwife)

Given names added from a supplemental report.

Address \_\_\_\_\_  
Filed 4-27 1921 E. E. Elmore  
Registrar \_\_\_\_\_



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH

County of *Minidoka*  
City of *Minidoka*

Registration District No. *19*Primary Registration District No. *2013*City of *Minidoka* St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Alice Seavitt*

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *34296*  
Registered No. *22*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*F*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*Single*  
(Write the word.)

## 6. DATE OF BIRTH

*Apr 26 1921*  
(Month) (Day) (Year)

## 7. AGE

Yrs. *1* Mos. *11* ds.

IF LESS than 1 day  
how many hrs. or  
min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

*none*

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*Louis Seavitt*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Idaho*

## 12. MAIDEN NAME OF MOTHER

*Bessie May*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Louis Seavitt*

(Address)

*Minidoka*

## 15.

Filed *191*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Stillborn 4-26-21*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

191..... to 191.....  
that I last saw h..... alive on 191.....  
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.  
(Signed) *[Signature]* M. D.

0-31-1921 (Address) *191 Minidoka*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

191

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

18913

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

385-224-034-385

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Minnesota

JUN 11 1921

CERTIFICATE OF BIRTH

City of HyburnBUREAU OF VITAL  
STATISTICSRegistration District No. 19File No. 90930

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2015 Registered No. 89

Hospital \_\_\_\_\_

FULL NAME OF CHILD StillbornSex of  
Child FTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate? ckDate of  
Birth May 24 1921

(Month) (Day) (Year)

(To be answered only in event of plural births)

FULL  
NAME

FATHER

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR st.AGE AT LAST  
BIRTHDAY 31

(Years)

COLOR st.AGE AT LAST  
BIRTHDAY 33

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 11:00 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address Busby IdaFiled June 3 1921

Registrar

Registrar

44 x 2

44 x 2

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTHBureau of Vital Statistics  
File No. 34303  
Registered No. 29  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of *Minidoka*  
City of *Heyburn*  
If death occurs away from usual residence, give facts called for under special information.  
Registration District No. *19*  
Primary Registration District No. *2013*  
St.)  
BUREAU OF VITAL STATISTICS

## 2. FULL NAME

*Siellhorn*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
*Infant*  
(Write the word.)6. DATE OF BIRTH *May 24 1921*  
(Month) (Day) (Year)7. AGE *Siellhorn*  
Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) *Idaho*

## 10. NAME OF FATHER

*J. L. Cherry*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Arizona*

## 12. MAIDEN NAME OF MOTHER

*Tinnie Cherry*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Arizona*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. L. Cherry*  
(Address) *Heyburn, Ida.*

15.

Filed *May 25 1921*

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 24 1921*  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Siellhorn* to *191*that I last saw h..... alive on *191*  
and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH was as follows:

*Siellhorn*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *P. J. C. Patheragon* M. D.5-29-19 (Address) *Builey, Ida.*  
\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted  
if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Heyburn Ida.*

## DATE OF BURIAL

*May 24 1921*

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in **months**.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

814-2241-03498

PLACE OF BIRTH

RECEIVED

JUN 11 1921

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO

BUREAU OF VITAL STATISTICS  
OFFICECounty of MinidokaCity of RupertRegistration District No. 19

File No.

S 90931

No. \_\_\_\_\_ St.

Primary Registration District No. 2010

Registered No.

90

Hospital \_\_\_\_\_

FULL NAME OF CHILD

StillbornSex of  
ChildFTwin  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti  
mate?yesDate of  
BirthMay 24 1921  
(Month) (Day) (Year)FULL  
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 5

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn,  
on the date above stated.

(Born alive or stillborn)

at 2:00 P. M.

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

D. J. Patterson  
M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Burley Ida

Filed

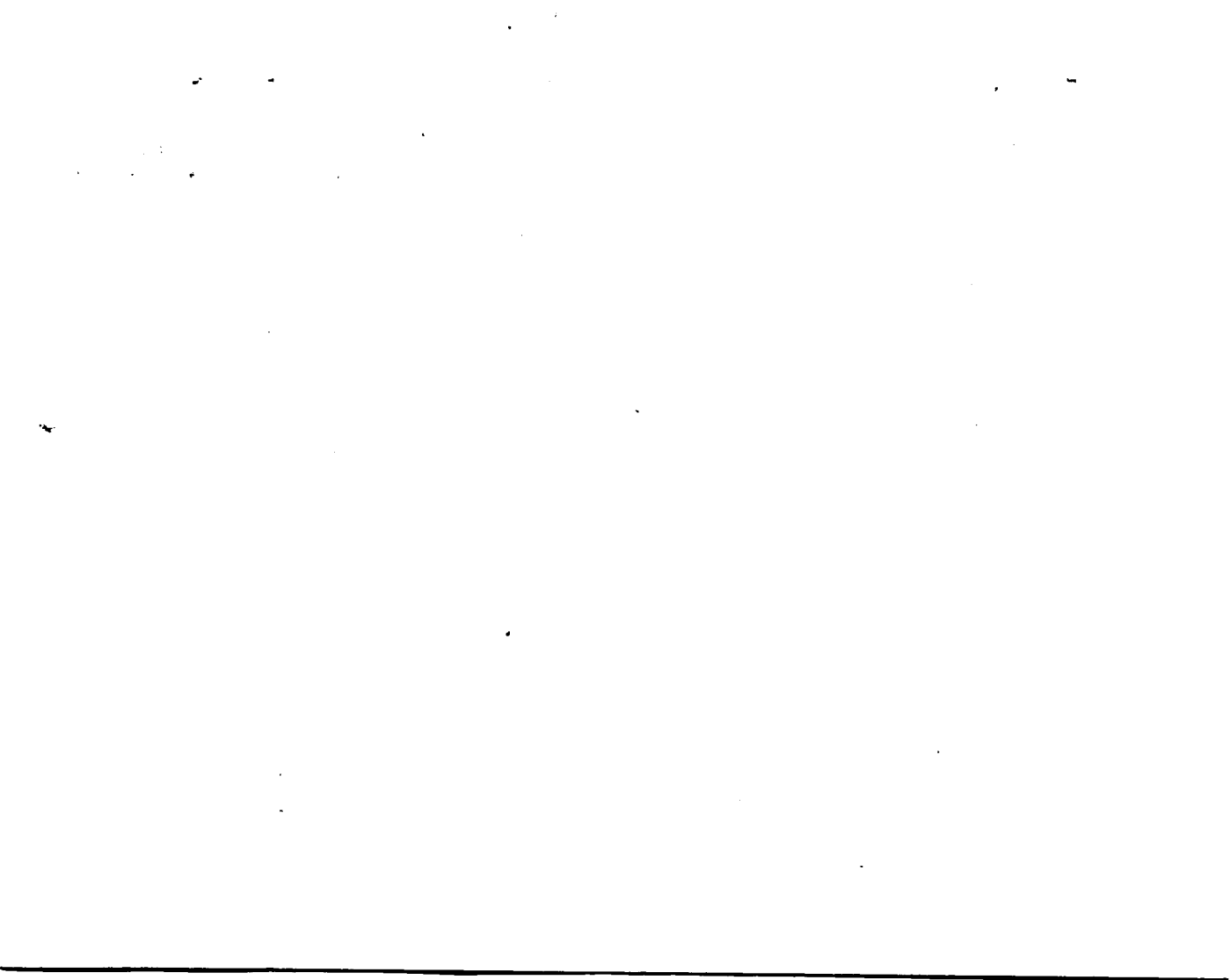
6-3

19

21Edith

Registrar

Registrar



34302

## 1. PLACE OF DEATH

County of *Minnesota*  
City of *Rupert*If death occurs away from  
usual residence, give facts  
called for under special  
information.

## CERTIFICATE OF DEATH

Registration District No. *19*Primary Registration District No. *2015*(No. *19* St.)BUREAU OF VITAL  
STATISTICSState of Idaho  
BOARD OF HEALTH

Bureau of Vital Statistics

File No. *34302*Registered No. *28*If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## 2. FULL NAME

*Steebman*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*F*

## 4. COLOR OR RACE

*Japanese*5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED*Infant*  
(Write the word.)

## 6. DATE OF BIRTH.

*May 24 1921*  
(Month) (Day) (Year)

## 7. AGE

*Infant*  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs. or  
min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which em-  
ployed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Idaho*10. NAME OF  
FATHER*N. Yamaguchi*11. BIRTHPLACE  
OF FATHER

(State or Country)

*Japan*12. MAIDEN NAME  
OF MOTHER*Shigi Miyoshi*13. BIRTHPLACE  
OF MOTHER

(State or Country)

*Japan*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*N. Yamaguchi*

(Address)

*Rupert, Ida.*

## 15.

Filed

*May 25 1921**E. D. Ehlers*  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*May 24 1921*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*Steebman* to *191*

that I last saw h. . . . . alive on . . . . . 191

and that death occurred on the date stated above, at . . . . . M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *Dr. J. C. Patterson* M. D.5-4-1921 (Address) *Rupert, Ida.*\*State the Disease Causing Death; or in deaths from Violent  
Causes, state (1) Means of Injury; and (2) whether Accidental,  
Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)At place In the  
of death . . . yrs. . . mos. . . days, State . . . yrs. . . mos. . . days

Where was disease contracted

if not at place of death?

Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Rupert, Ida.*

## DATE OF BURIAL

*May 24 1921*

## 20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles, Whooping cough, Chronic valvular heart disease, Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

512-280-034-292

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of Mindoka STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCity of Rupert CERTIFICATE OF BIRTHNo. \_\_\_\_\_ St. RECEIVED  
JUN 11 1921  
BUREAU OF VITAL STATISTICS  
Registration District No. 19 File No. 90936Hospital \_\_\_\_\_ Primary Registration District No. 2015 Registered No. 95FULL NAME OF CHILD Stillborn

Sex of Child <u>F.</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>y</u>	Date of Birth <u>Mar. 30</u> 19 <u>21</u>
(To be answered only in event of plural births)				(Month)	(Day) (Year)

FATHER		MOTHER	
FULL NAME <u>H. Nakaya</u>	FULL MAIDEN NAME <u>Tone Kishiyama</u>	FULL NAME <u>Tone Kishiyama</u>	FULL MAIDEN NAME <u>Tone Kishiyama</u>
RESIDENCE <u>Rupert Ida</u>	RESIDENCE <u>Idaho</u>	RESIDENCE <u>Idaho</u>	RESIDENCE <u>Idaho</u>
COLOR <u>Japanese</u> AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>Japanese</u> AGE AT LAST BIRTHDAY <u>26</u> (Years)	COLOR <u>Japanese</u> AGE AT LAST BIRTHDAY <u>26</u> (Years)	COLOR <u>Japanese</u> AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Japan</u>	BIRTHPLACE <u>Japan</u>	BIRTHPLACE <u>Japan</u>	BIRTHPLACE <u>Japan</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Farmer</u>	OCCUPATION <u>Farmer</u>	OCCUPATION <u>Farmer</u>

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 10:00 A.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. J. C. Patterson  
MD. (Physician or midwife)

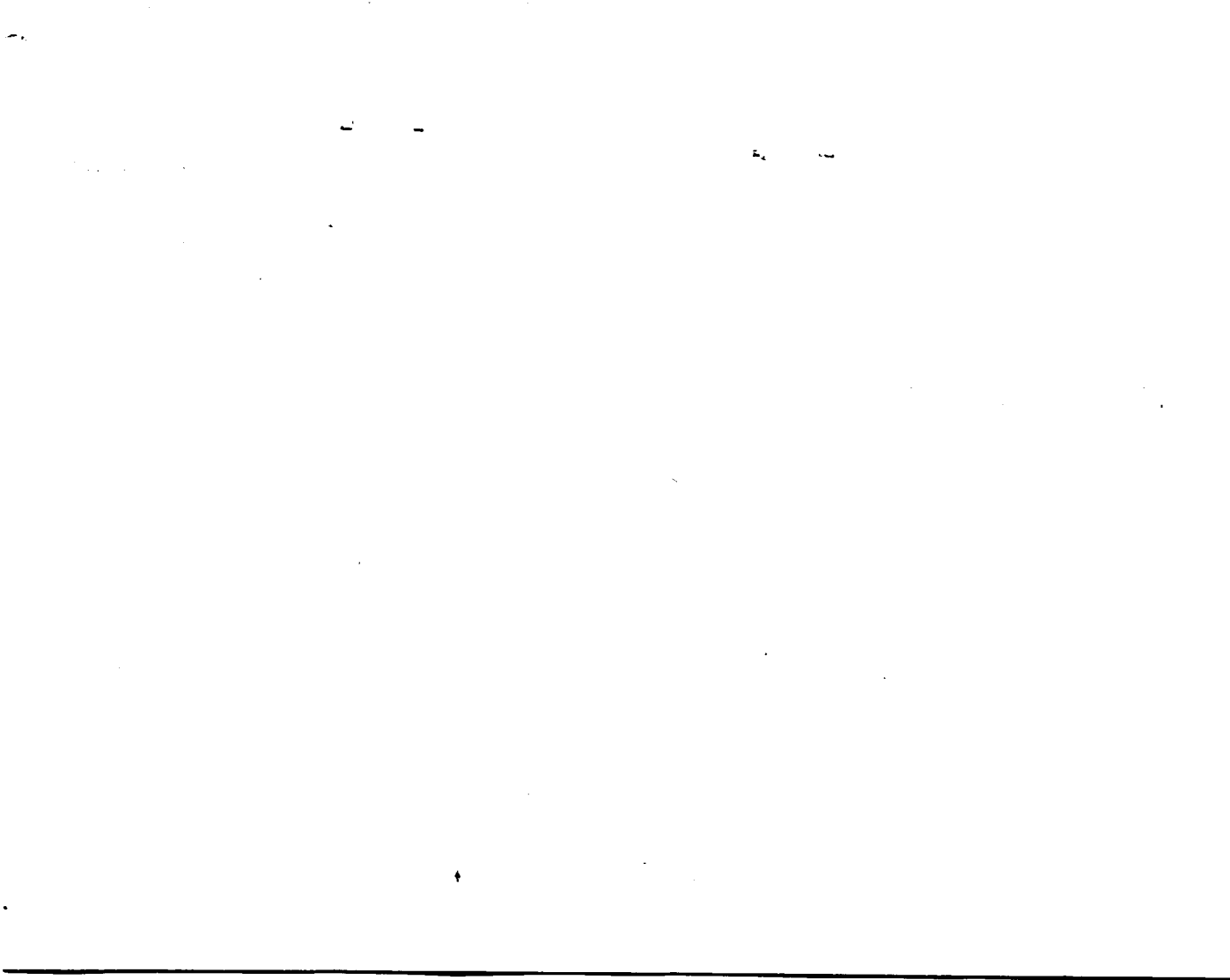
Given names added from a supplemental report.

19

Address Burley IdaFiled 4-16 1921

Registrar

Registrar



1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

## RECEIVED CERTIFICATE OF DEATH

Registered District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

St.)

State of Idaho  
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 34297

Registered No. 2387

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH.

Mar. 30 1921  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many hrs. or min.?

Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

Steelborn

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. Nakaya

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Ione Kishiyama

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. Nakaya  
Rupert, Ida.

15.

Filed 4-16 1921

E. E. Elmore

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Steelborn 191  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

S. Steelborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. C. Patterson M. D.

19. Address) Busley, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

Rupert Ida

DATE OF BURIAL

Mar. 30 1921

20. UNDERTAKER

ADDRESS

1890

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers, who receive a definite salary*) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



413-130-035-296

## PLACE OF BIRTH

County of NebraskaCity of LevistonNo. 1504Hospital WhiteFULL NAME OF CHILD Matthe

RECEIVED  
JUN 13 1921  
BUREAU OF VITAL  
STATISTICS

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. &amp; No. 11-0-22-8-17

Registration District No. 96File No. S-90945Primary Registration District No. 1009Registered No. 684

Sex of Child Male Twin no Triplets X and (Number in order of birth) X 1st born Legitimate? yes Date of Birth 4 30 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FULL NAME C. C. Matthe FATHER  
RESIDENCE Leviston, Ida.  
COLOR white AGE AT LAST BIRTHDAY 38 (Years)  
BIRTHPLACE Iowa  
OCCUPATION Bookkeeper

FULL MAIDEN NAME Leith Brown MOTHER  
RESIDENCE Leviston, Ida.  
COLOR white AGE AT LAST BIRTHDAY 31 (Years)  
BIRTHPLACE Nebraska  
OCCUPATION H. W.

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

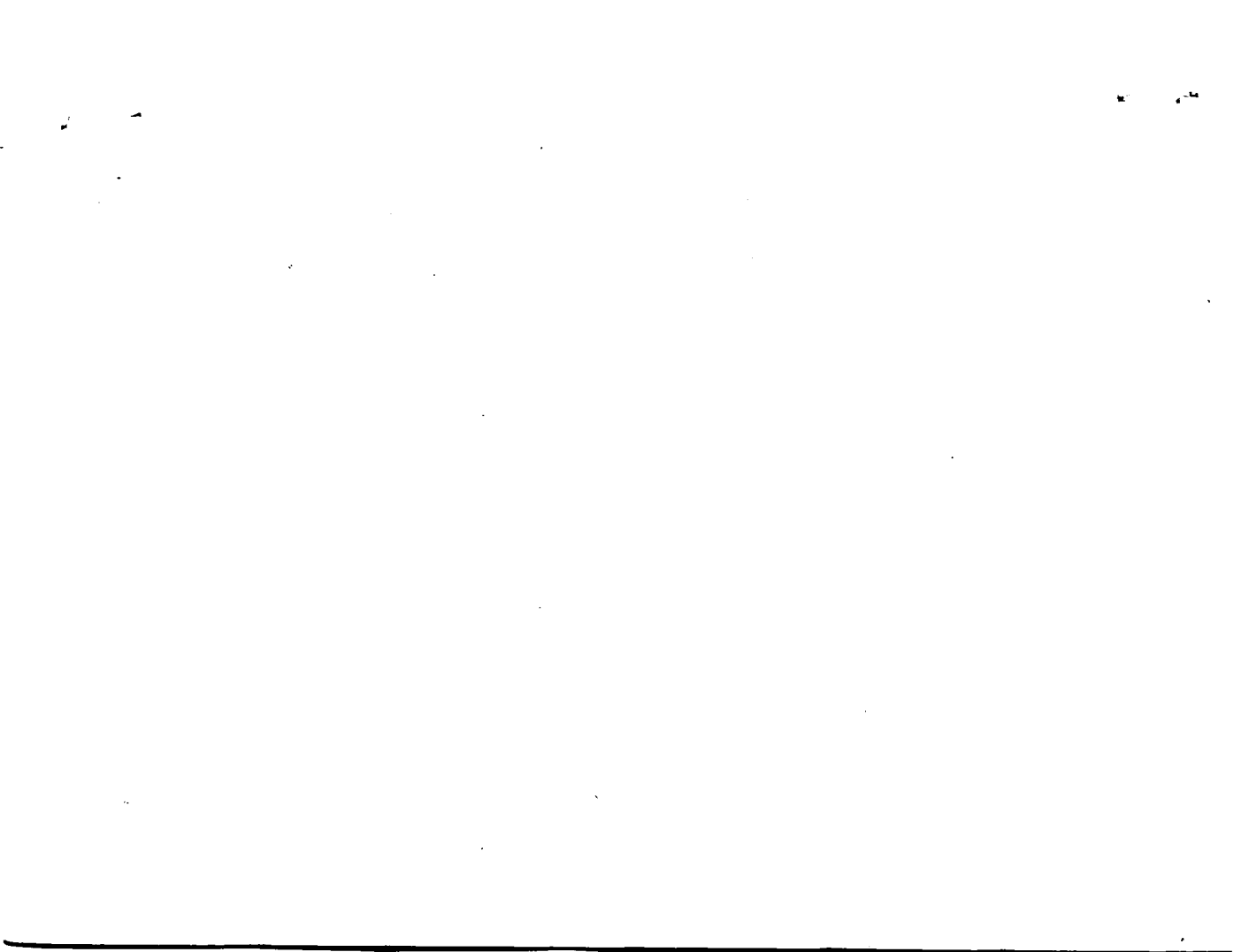
I hereby certify that I attended the birth of this child, who was born or stillborn, at 12 45 A. M. on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. J. White(Physician or midwife) H. O. Clark

Given names added from a supplemental report.

Address LevistonFiled June 10 1921Russell E. Brown



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **34318**  
Registered No. **659**

## 1. PLACE OF DEATH

County of **My Puel**  
City of **Furnston**

RECEIVED

JUN 18 1921

BUREAU OF VITAL STATISTICS

Registration District No. **96**Primary Registration District No. **1009**

St.)

Registered No. **659**

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Stillborn**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

**Male**

## 4. COLOR OR RACE

**white**

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

**Infant**  
(Write the word.)

## 6. DATE OF BIRTH

**April 30 1921**  
(Month) (Day) (Year)

## 7. AGE

**0** Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

**Furnston Idaho**

## 10. NAME OF FATHER

**C C Motter**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Iowa**

## 12. MAIDEN NAME OF MOTHER

**Ruth Brown (Motter)**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Nebraska**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

**W O Clark**

(Address)

**Furnston Idaho**

## 15.

Filed **June 8 1921**

**Ernest E. Bruce**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**April 30 1921**  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at **12:43 AM**

The CAUSE OF DEATH was as follows:

**Stillborn Infant**  
**Regeneration**

(Duration) Yrs. mos. ds.  
Contributory (Secondary) **Premature separation of placenta**

(Duration) yrs. mos. ds.

(Signed) **W O Clark** M. D.

**May 1 1921** (Address) **Furnston Idaho**

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

**Cremated**

## DATE OF BURIAL

19

## 20. UNDERTAKER

**None**

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

413.230-035-296

PLACE OF BIRTH County of <u>Jefferson</u>		STATE OF IDAHO BUREAU OF VITAL STATISTICS		Form V. & No. 11-C—Rev. 9-17	
City of <u>Lewiston</u>		RECEIVED JUN 13 1921		S	
No. <u>15741 Main St.</u>		BUREAU OF VITAL STATISTICS		Certificate of Birth	
Hospital <u>White</u>		Primary Registration District No. <u>1009</u>		File No. <u>90946</u>	
FULL NAME OF CHILD		Registered No. <u>6865</u>			
Sex of Child <u>Female</u>		Twin <u>Yes</u> or other? <u>X</u>		Legitimate? <u>Yes</u>	
Date of Birth <u>4 30 1921</u>		Number in order of birth <u>2nd born</u>		(Month) (Day) (Year)	
FULL NAME <u>C. C. Matter</u>		FATHER		FULL MAIDEN NAME <u>Ruth Brown</u>	
RESIDENCE <u>Lewiston Id.</u>		RESIDENCE		RESIDENCE <u>Lewiston Id.</u>	
COLOR <u>White</u>		AGE AT LAST BIRTHDAY <u>38</u> (Years)		COLOR <u>White</u>	
BIRTHPLACE <u>Iowa</u>		BIRTHPLACE		BIRTHPLACE <u>Id.</u>	
OCCUPATION <u>Bookkeeper</u>		OCCUPATION		OCCUPATION <u>H. W.</u>	

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive or stillborn at 12 42 A.M. on the date above stated.

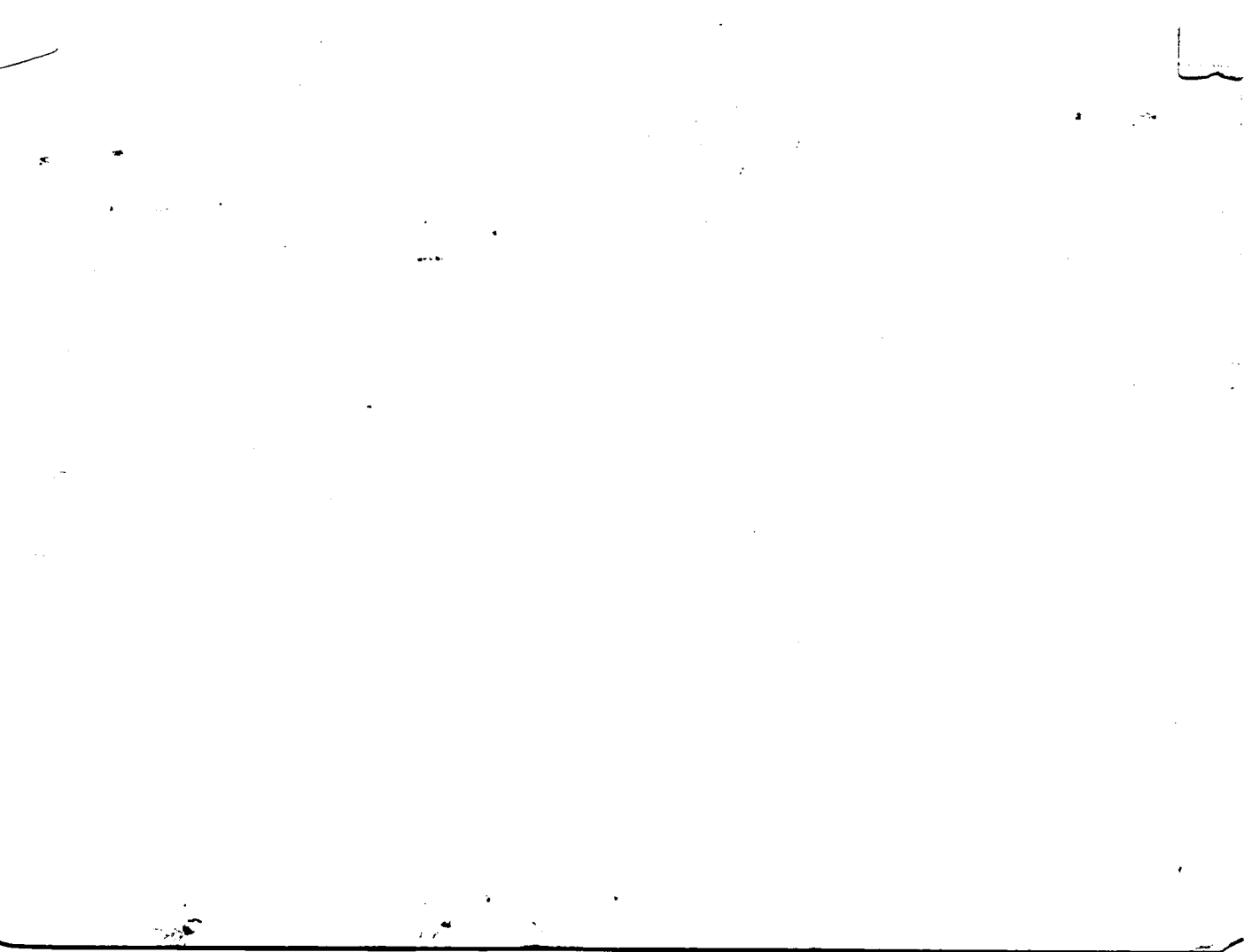
{ \*When there was no attending physician or midwife then the father, householder, etc., could make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Signature) Edgar L. White  
W. O. Clark  
(Physician or midwife)

Given names added from a supplemental report.

Address Lewiston Idaho

Filed June 10 1921 Bessie E. Brown



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Nez Perce*  
City of *Lewiston*Registration District No. *96*

RECEIVED

JUN 13 1921

Registration District No. *1009*

St.)

- File No. *34317*Registered No. *658*

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Stillborn*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Female white*

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Infant*  
(Write the word.)

## 6. DATE OF BIRTH

*April 30 1921*  
(Month) (Day) (Year)

## 7. AGE

*0* Yrs. Mos. ds.IF LESS than 1 day  
how many... hrs.  
or... min.?

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work.
- 
- (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) *Lewiston Idaho*

## 10. NAME OF FATHER

*C C Matter*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Iowa*

## 12. MAIDEN NAME OF MOTHER

*Ruth Brown Matter*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Nebraska*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W O Clark*(Address) *Lewiston Idaho*

## 15.

Filed *June 8 1921* *Irwan C. Bruce*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*April 30 1921*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...

that I last saw him alive on 19...

and that death occurred on the date stated above, at *1246*

The CAUSE OF DEATH\* was as follows:

*Stillborn, intra-uterine degeneration*(Duration) Yrs. mos. ds.  
Contributory (Secondary) *Premature degeneration of placenta*

(Duration) Yrs. mos. ds.

(Signed) *W O Clark* M. D.*May 10 1921* (Address) *Lewiston Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Prepared* *May 1st 1921*

## 20. UNDERTAKER

## ADDRESS

*None. (Permission given)*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also, (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

349-131-035-289

PLACE OF BIRTH

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

County of Nez Perce

RECEIVED

CERTIFICATE OF BIRTH

JUN 13 1921

City of Lewiston

BUREAU OF VITAL STATISTICS

96

File No.

S

90966

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 1009

Registered No. 705

Hospital St. Joseph's

FULL NAME OF CHILD

Willborn Turner

Sex of Child Male

Twin  
Primer  
or other?

and

Number  
in order  
of birth

2

Legiti  
mate?

Yes

Date of  
Birth

May 31st

1921

(Year)

(To be answered only in event of plural births)

FULL  
NAME

Raymond Turner

FATHER

FULL  
MAIDEN  
NAME

Margorie Shier

MOTHER

RESIDENCE

Sites, Idaho

RESIDENCE

Sites, Idaho

COLOR

white

AGE AT LAST  
BIRTHDAY

43

(Years)

COLOR

white

AGE AT LAST  
BIRTHDAY

38

(Years)

BIRTHPLACE

Ohio

BIRTHPLACE

Michigan

OCCUPATION

Creamery man

OCCUPATION

Housewife

Number of child of this mother, including present birth. 2 Number of children of this mother now living, including present birth. 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_, at 4 a. M. on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. B. Braddock

Lewiston, Idaho

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Lewiston, Idaho

Filed

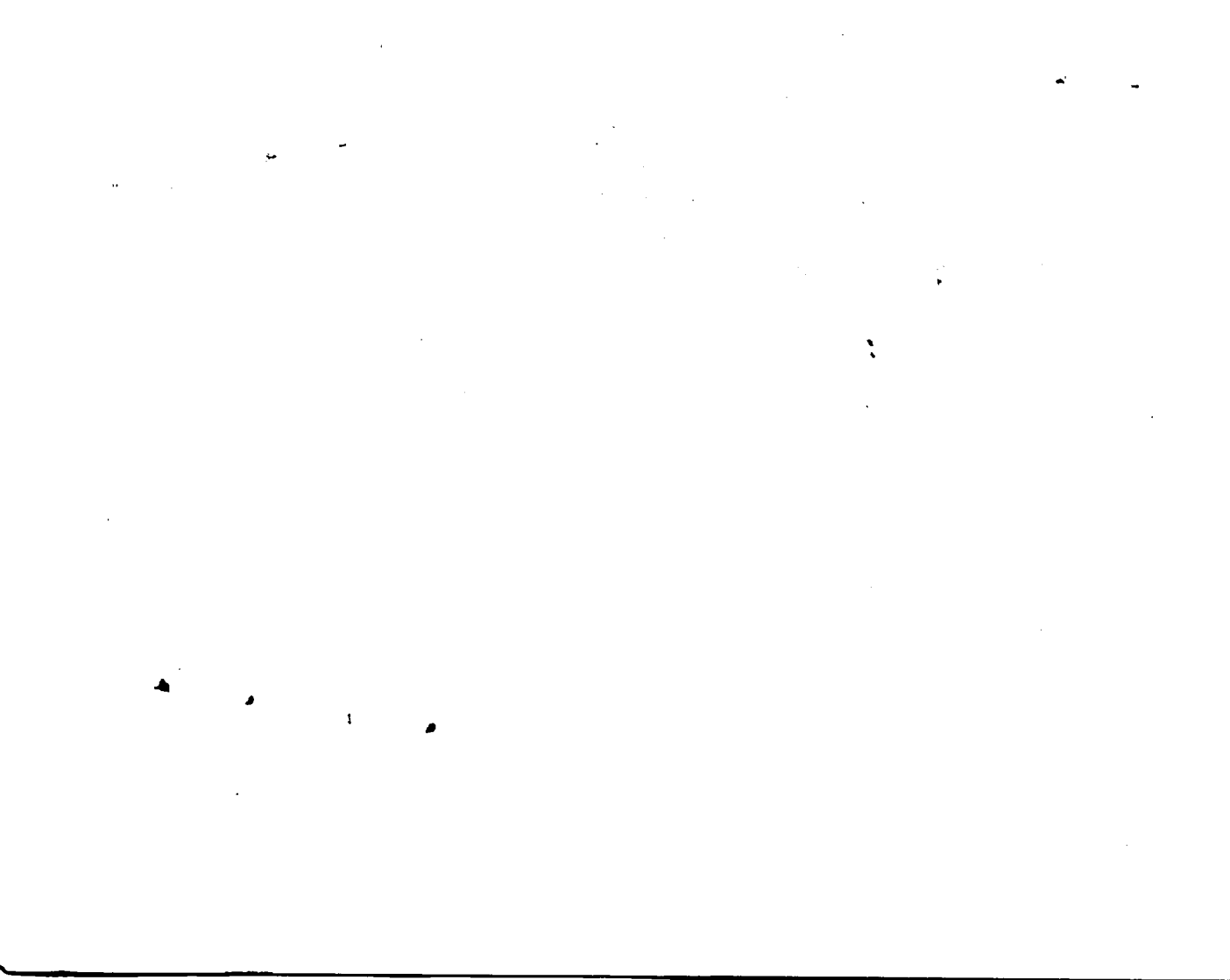
Jun 10

1921

Arson E. Brum

Registrar

Registrar



FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

JUN 13 1921 CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *My Place*City of *Leaviston*

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

Registration District No. *96*Registration District No. *1009*

(No. ....)

St.)

File No. *34320*Registered No. *661*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Baby, Turner*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male**White**Infant*

## 6. DATE OF BIRTH

*May**31**1921*

(Month)

(Day)

(Year)

## 7. AGE

Yrs. ....

Mos. ....

ds. ....

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

*Infant*

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*R. D. Turner*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Ohio*

## 12. MAIDEN NAME OF MOTHER

*Margaret Shier*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Michigan*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*R. D. Turner*

(Address)

*Stites, Idaho*

## 15.

Filed

*June 8**1921**Rusam E Bruce*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*May 31*

(Month)

(Day)

*1921*  
(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*May 31, 1921, to May 31, 1921*that I last saw him alive on *May 31, 1921*and that death occurred on the date stated above, at *5 P.M.*

The CAUSE OF DEATH\* was as follows:

*Premature Birth  
7 mos gestation*

.....(Duration) .....Yrs.....mos.....ds.

Contributory  
(Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed)

*E. S. Braddock M. D.**1-1 1921* (Address) *Leaviston Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Leaviston, Idaho**6/2 1921*

## 20. UNDERTAKER

## ADDRESS

*Leaviston Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

493-231-275-962

## PLACE OF BIRTH

County of NezperceCity of LewistonNo. 0315-2nd St. St.

Hospital .....

FULL NAME OF CHILD .....

RECEIVED  
MAY 20 1921  
BUREAU OF VITAL  
STATISTICS

Primary Registration District No. 1009

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-2-5-17

File No. 90982Registered No. 671

Sex of Child 49 Twin Triplet or other? and Number in order of birth 96 Legitimate? yes Date of Birth 3 - 31 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FULL NAME FATHER Lloyd Milet  
RESIDENCE not known  
COLOR W AGE AT LAST BIRTHDAY 20 (Years)  
BIRTHPLACE Wn.  
OCCUPATION Laborer

FULL MAIDEN NAME MOTHER Lothie Robinson  
RESIDENCE Lewiston  
0315-2nd St.  
COLOR W AGE AT LAST BIRTHDAY 18 (Years)  
BIRTHPLACE Minw.  
OCCUPATION at home

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was 1 still born at 1:45 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. F. McMahon, M.D.

Given names added from a supplemental report.

(Physician or midwife)  
Address Lewiston, Idaho.

Filed May 10 1921 Arnan E. Brune  
Registrar



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Payson  
 City of Lewiston

Registration District No. 96Primary Registration District No. 1009

APR 16 1921

BUREAU OF VITAL  
STATISTICS

If death occurs away from  
 usual residence, give facts  
 called for under special in-  
 formation.

## 2. FULL NAME

Margh. Milot

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 33943  
 Registered No. 627  
 If death occurred in a hos-  
 pital, institution or camp,  
 give its NAME instead of  
 street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

Wk5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDSingle

## 6. DATE OF BIRTH

March 31 1921  
 (Month) (Day) (Year)

## 7. AGE

Yrs. Mos. da.

IF LESS than 1 day  
 how many hrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or  
 particular kind of work.  
 (b) General nature of in-  
 dustry, business or estab-  
 lishment in which employ-  
 ed (or employer).

Infant

## 9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF  
FATHERElmer Milot11. BIRTHPLACE  
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME  
OF MOTHERLottie Milot13. BIRTHPLACE  
OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Alice Robinson

(Address)

0135 2nd St. City

## 15.

Filed

Apr 12 1921Susan E Bruce

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

3 - 31 - 1921  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
3-31-1921 to same 1921

that I last saw her alive on stillborn 1921  
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

not known

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. F. Mc Mahan M. D.4-1-1921(Address) Lewiston, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted  
 if not at place of death?

Former or  
 usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Lewiston, IdaApr 1, 1921

## 20. UNDERTAKER

## ADDRESS

Vassar & CoLewiston

109

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

653-118-075-658  
PLACE OF BIRTH *County*  
County of *My Prec*  
City of *Spading*  
No. *95*  
St. *St.*  
BUREAU OF VITAL STATISTICS  
RECEIVED  
MAY 20 1921

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S90989

Hospital \_\_\_\_\_  
Primary Registration District No. *1009* Registered No. *679*  
FULL NAME OF CHILD *Wilbur Lee Welch*

Sex of Child *male* { Twin *Single* or other? } and { Number in order of birth *2* } Legiti mate? *yes* Date of Birth *April 18th 1921*  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME *W.O. Welch*  
RESIDENCE *Spading, Idaho*  
COLOR *white* AGE AT LAST BIRTHDAY *27* (Years)  
BIRTHPLACE *Missouri*  
OCCUPATION *Farmer*

MOTHER  
FULL MAIDEN NAME *Grace Felling*  
RESIDENCE *Spading, Idaho*  
COLOR *white* AGE AT LAST BIRTHDAY *20* (Years)  
BIRTHPLACE *Idaho*  
OCCUPATION *Housewife*

Number of child of this mother, including present birth *2* Number of children of this mother now living, including present birth *1*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was *still born*, at *10.30 p. M.*  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *E. S. Braddock*  
*Leaverton, Idaho*  
(Physician or midwife)

Given names added from a supplemental report.

Address \_\_\_\_\_  
Filed *May 10 1921* *Arnan E. Brum*  
Registrar Registrar



55-9-221-029-963  
PLACE OF BIRTHSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-9

County of LatahCity of MoscowNo. RW St.

Hospital .....

RECEIVED  
JUN 9 1921  
BUREAU OF VITAL  
STATISTICS  
Registration District No. 61  
Primary Registration District No. 2041File No. **S 91001**Registered No. 78

## FULL NAME OF CHILD .....

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> Number in order of birth <u>1</u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of Birth <u>May 21</u> 19 <u>21</u> (Month) (Day) (Year)
----------------------------	--	------------------------	--

FULL NAME <u>Frank</u> FATHER <u>Russ</u>
RESIDENCE <u>Moscow Idaho</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>59</u> (Years)
BIRTHPLACE <u>Sweden</u>
OCCUPATION <u>Farming</u>

FULL MAIDEN NAME <u>Della May</u> MOTHER <u>Rockwood</u>
RESIDENCE <u>Moscow, Idaho</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>41</u> (Years)
BIRTHPLACE <u>Kansas</u>
OCCUPATION <u>Housewife</u>

Number of child of this mother, including present birth..... Number of children of this mother now living, including present birth.....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born at 4:40 a. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas. L. Gutman

(Physician or midwife)

Given names added from a supplemental report.

Address Moscow IdahoFiled May 30 1921 W. H. Leathers

Registrar

Registrar



FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED

Registration District No.

County of

JUL 9 1921

Registration District No.

City of

BUREAU OF VITAL  
STATISTICS

St.)

File No.

Registered No.

If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

2. FULL NAME

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

16. DATE OF DEATH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or  
particular kind of work.(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF  
FATHER11. BIRTHPLACE  
OF FATHER

(State or Country)

12. MAIDEN NAME  
OF MOTHER13. BIRTHPLACE  
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5/21/1921

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted  
if not at place of death?Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

ED FOR BINDING

NK—THIS IS A PERMANENT RECORD

WRITE PLAINLY WITH U.S.

ABSTRACT RETURN must be made for each and the number of children of birth stated.

493-105-PLAC

Form V. S. No. 11-C-25m-9-8-15

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 91022

03-693  
County of Blaine

City of Heppner  
No. Village St.

JUN 9 1921  
BUREAU OF VITAL STATISTICS  
Registration No. 47

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_ Registered No. 123

Hospital \_\_\_\_\_

FULL NAME OF CHILD Steve Brown

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and in order of birth	Legitimate? <u>Yes</u>	Date of Birth <u>Jun - 5 - 1921</u> Month (Day) (Year)
FATHER FULL NAME <u>Henry Michael</u> RESIDENCE <u>Heppner</u> COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>50</u> (Years) BIRTHPLACE <u>Mo.</u> OCCUPATION <u>Farmer</u>			MOTHER FULL MAIDEN NAME <u>Anna Anna Williams</u> RESIDENCE <u>Heppner</u> COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>36</u> (Years) BIRTHPLACE <u>Oklahoma</u> OCCUPATION <u>House wife</u>	

Number of child of this mother, including present birth. 4th Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Steve Brown at 3:10 M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) John F. Gist M.D.  
Myerson Idaho  
(Physician or midwife)

Given names added from a supplemental report.

Albert Huff 19  
Registrar

Address \_\_\_\_\_  
Filed 6-1 19 21 Albert Huff  
Registrar

RECEIVED BY THE BUREAU OF THE STATE OF NEW YORK  
 DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS  
 ALBANY, N. Y.

STATE OF NEW YORK  
 BUREAU OF VITAL RECORDS  
 CERTIFICATE OF BIRTH

Child's Name: \_\_\_\_\_  
 Sex of Child: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Place of Birth: \_\_\_\_\_  
 Hospital: \_\_\_\_\_  
 Full Name of Child: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_  
 Birthplace: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Signature of Physician or Midwife: \_\_\_\_\_  
 Date: \_\_\_\_\_

STATE OF NEW YORK  
 BUREAU OF VITAL RECORDS  
 CERTIFICATE OF BIRTH

Child's Name: \_\_\_\_\_  
 Sex of Child: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Place of Birth: \_\_\_\_\_  
 Hospital: \_\_\_\_\_  
 Full Name of Child: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_  
 Birthplace: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Signature of Physician or Midwife: \_\_\_\_\_  
 Date: \_\_\_\_\_



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

# CERTIFICATE OF DEATH

1. **PLACE OF DEATH**  
 County of Lewis  
 City of Nezperce Village  
 If death occurs away from usual residence, give facts called for under special information.  
 2. **FULL NAME** Will born

REGISTERED JUN 9 1921  
 BUREAU OF VITAL STATISTICS  
 District No. 47  
 Primary Registration District No. .... St.)

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 34585  
 Registered No. ....  
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** female  
 4. **COLOR OR RACE** white  
 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** (Write the word.)  
 6. **DATE OF BIRTH** Jan 5 1921  
 (Month) (Day) (Year)  
 7. **AGE** Infants  
 IF LESS than 1 day how many .... hrs. or .... min.?  
 Yrs. .... Mos. .... ds.

8. **OCCUPATION**  
 (a) Trade, profession or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. **BIRTHPLACE**  
 (State or Country)

10. **NAME OF FATHER** Henry Nichols

11. **BIRTHPLACE OF FATHER** Missouri  
 (State or Country)

12. **MAIDEN NAME OF MOTHER** Anna Laura Williams

13. **BIRTHPLACE OF MOTHER** Oklahoma  
 (State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) Henry Nichols  
 (Address) Nezperce Village

15. Filed 6-1 19121 Albert Huff  
 Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Jan 8 19121  
 (Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan 5 1921 to Jan 8 1921  
 (that I last saw him alive on Jan 5 1921 and that death occurred on the date stated above, at 9:19 M.

The **CAUSE OF DEATH\*** was as follows:  
Will born

(Duration) Yrs. .... mos. .... ds.

Contributory (Secondary)

(Duration) Yrs. .... mos. .... ds.

(Signed) John H. East M. D.  
 19.... (Address) Nezperce Village

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days, In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Nezperce Cemetery

20. **UNDERTAKER** Albert Huff

DATE OF BURIAL Jan 5 19121

ADDRESS Nezperce Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH. (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

493-105-031-693  
PLACE OF BIRTHCounty of LewisCity of NepeseeNo. Village St.

Hospital

FULL NAME OF CHILD

Shirley BornSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—25m-9-8-15

## CERTIFICATE OF BIRTH

RECEIVED  
JUN 9 1921  
BUREAU OF VITAL  
STATISTICSPrimary Registration District No. 1

File No.

S 91023

Registered No.

123

Sex of Child <u>Male</u>	Twin Triplet or other? <u>Twin</u> (To be marked accordingly in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth <u>June 3 1921</u> (Month) (Day) (Year)
FULL NAME <u>Shirley Michels</u>	FATHER		FULL MAIDEN NAME <u>Anna Laura Williams</u>	MOTHER
RESIDENCE <u>Nepesee Ida</u>			RESIDENCE <u>Nepesee</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>5-0</u> (Years)		COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>3-6</u> (Years)
BIRTHPLACE <u>Mo.</u>			BIRTHPLACE <u>Oklahoma</u>	
OCCUPATION <u>Farmer</u>			OCCUPATION <u>House wife</u>	
Number of child of this mother, including present birth <u>5th</u>			Number of children of this mother now living, including present birth <u>3</u>	

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Shirley Born at 3 30 A.M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

John F. Gist M.D.  
Nepesee Idaho  
(Physician or midwife)

Given names added from a supplemental report.

Address

Filed

6-1 1921

ОРОДОН ТУЛГАМРАА АН ГЭНТ-ЭН И ОМГОГОО МОНГО УЛСАЙ ЭТИВЭ

in case of death, to any of the following persons:

1948

2329 6

● 2009 年 12 月 1 日

DATA JUNKIES

YACHTING

(1999)

32A-194718

COMPTON

PHYSICIAN ON DUTY

(attached to syll. sheet)

1045732

...вместе с другими ...

**Accepted**

**Endre**

7-10-62

**CLERK TO SENATE**

CHILD

1948

● 2009 年 12 月 1 日

DATA JUNKIES

YACHTING

(1999)

32A-194718

COMPTON

PHYSICIAN ON DUTY

(attached to syll. sheet)

1045732

...вместе с другими ...

**Accepted**

**Endre**

7-10-62

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 47

County of Lewis

Registration District No.

City of Nepesee

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BUREAU OF VITAL STATISTICS

RECEIVED JUN 9 1921

BO. HEALTH  
Bureau of Vital Statistics,  
File No. 34580  
Registered No.  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day  
how many hrs. or  
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

6-1

1912

Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

(Address)

Yrs.

mos.

ds.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. days, State yrs. mos. days

Where was disease contracted

if not at place of death?

Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH  
2. FULL NAME  
3. SEX  
4. COLOR OR RACE  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED.  
6. DATE OF BIRTH.  
7. AGE  
8. OCCUPATION  
9. BIRTHPLACE  
10. NAME OF FATHER  
11. BIRTHPLACE OF FATHER  
12. MAIDEN NAME OF MOTHER  
13. BIRTHPLACE OF MOTHER  
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
15.  
16. DATE OF DEATH  
17. I HEREBY CERTIFY, That I attended deceased from  
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
19. PLACE OF BURIAL OR REMOVAL  
20. UNDERTAKER

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

297-1211036-819

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of ShoshoneCity of Stone

No. \_\_\_\_\_

RECEIVED  
JUN 4 1921  
BUREAU OF VITAL  
STATISTICSRegistration District No. 26

File No. \_\_\_\_\_

S 91037

Hospital \_\_\_\_\_

Primary Registration District No. 2064Registered No. 63

## FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? <u>No</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>May 2</u> 19 <u>21</u> (Month) (Day) (Year)
FATHER Full Name <u>Galek James Bradshaw</u> Residence <u>Stone Idaho</u>			MOTHER Full Maiden Name <u>Imanda Rena Harris</u> Residence <u>Stone</u>		
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)	BIRTHPLACE <u>Dixie Utah</u>		OCCUPATION <u>Farmer</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)	BIRTHPLACE <u>Stone Idaho</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth \_\_\_\_\_ Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:05 a.m.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Clara Sadleir M.D.

(Physician or midwife)

Given names added from a supplemental report.

19 \_\_\_\_\_

Address Snowville UtahFiled June 4 1921

Registrar \_\_\_\_\_

Registrar RTM

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF ILLINOIS

STATEMENT OF PUBLIC DEBT



RECEIVED  
JUL 21 1921  
BUREAU OF VITAL  
STATISTICS

DEPART

BUBLIC WELFARE

Boise, Idaho,.....JUL 1 1921.....192...

adam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

City .....Stone.....  
Place {  
of { Street .....  
Birth { County .....Omeida.....  
Sex of Child.....Male.....  
Date of Birth .....May 21st 1921.....  
Father Robt. James Brackhaus Amanda Elestha Leona Turner  
Full Name not Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Premature Baby and Dead Born  
Child's Name in Full

Robt. J. Brackhaus  
Signature of Father or Mother

142

249-104038-653

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

Payette. RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

County of Payette. JUN 3 1921

City of BUREAU OF VITAL  
STATISTICS

Registration District No. 4 1008

File No. S 91052

No. St.

Primary Registration District No. Registered No. 46

Hospital

FULL NAME OF CHILD Unnamed-born dead

Sex of Child Male	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? Yes	Date of Birth May 4, 1921 (Month) (Day) (Year)
-------------------	---	-----	--------------------------------	---------------------	---

FULL NAME FATHER  
Carroll J. BurnsFULL MAIDEN NAME MOTHER  
Fanny L. Wells

RESIDENCE Payette, Idaho

RESIDENCE Payette, Idaho

COLOR White AGE AT LAST BIRTHDAY 22  
(Years)COLOR White AGE AT LAST BIRTHDAY 20  
(Years)

BIRTHPLACE Clarke County, Illinois

BIRTHPLACE Kentucky

OCCUPATION Truck Driver

OCCUPATION Wife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was born dead, at 3.30 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Physician

(Physician or midwife)

Given names added from a supplemental report.

19

Address Payette, Idaho

Filed April 4 1921

May 4, 1921

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

RECEIVED  
JUN 3 1951  
COUNTY OF ...  
CITY OF ...

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **34352**  
Registered No. **17**

1. PLACE OF DEATH **RECEIVED**  
Registration District No. **4**  
County of **Payette** JUN 3 1921 Primary Registration District No. **1008**  
City of **Payette** BUREAU OF VITAL STATISTICS St.)  
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Unnamed-Born dead.**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-OWED OR DIVORCED **Infant**  
(Write the word.)

6. DATE OF BIRTH

**May 4, 1921**  
(Month) (Day) (Year)

7. AGE

----- Yrs. ----- Mos. ----- ds.

IF LESS than 1 day  
how many ----- hrs.  
or ----- min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. -----  
(b) General nature of industry, business or establishment in which employed (or employer). -----

9. BIRTHPLACE

(State or Country)

**Payette, Idaho**

10. NAME OF FATHER

**Carroll J. Burns**

11. BIRTHPLACE OF FATHER

(State or Country)

**Clarke County, Illinois**

12. MAIDEN NAME OF MOTHER

**Fanny L. Wells**

13. BIRTHPLACE OF MOTHER

(State or Country)

**Kentucky.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

**Payette, Idaho**

15.

Filed **May 4, 1921**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **May 4, 1921**

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 4, 1921** to **May 4, 1921**

that I last saw him alive on -----  
and that death occurred on the date stated above, at ----- M.

The CAUSE OF DEATH\* was as follows:

**True Knot in umbilical cord**

(Duration) ----- Yrs. ----- mos. ----- ds.

Contributory  
(Secondary)

(Duration) ----- yrs. ----- mos. ----- ds.

(Signed)

**5/4/21**

(Address)

**Payette, Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ----- yrs. ----- mos. ----- days. In the State ----- yrs. ----- mos. ----- days

Where was disease contracted if not at place of death?

Former or usual residence -----

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

**Payette, Idaho** **May 5, 1921**

20. UNDERTAKER

ADDRESS

**Carroll J. Burns** **Payette, Idaho**

2-291  
A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

655-208039-766  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED JUN 9 1921

BUREAU OF VITAL

STATISTICS

S91956

County of Brewer

City of Aberdeen P.O.

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration 2072

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 310

Registered No. 310

FULL NAME OF CHILD

Ethel Anolia Fenstermaker

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u> and <u>—</u> Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of birth <u>May 8</u> 1921 (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FATHER  
FULL NAME Meryl Edward Fenstermaker

MOTHER  
FULL MAIDEN NAME Jessie Anolia Powell

RESIDENCE Aberdeen Ida

RESIDENCE Aberdeen Ida

COLOR White AGE AT LAST BIRTHDAY 28  
(Years)

COLOR White AGE AT LAST BIRTHDAY 34  
(Years)

BIRTHPLACE Ohio

BIRTHPLACE Ohio

OCCUPATION Farmer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

still born at 10:30 P. M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

M. C. Markin, M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

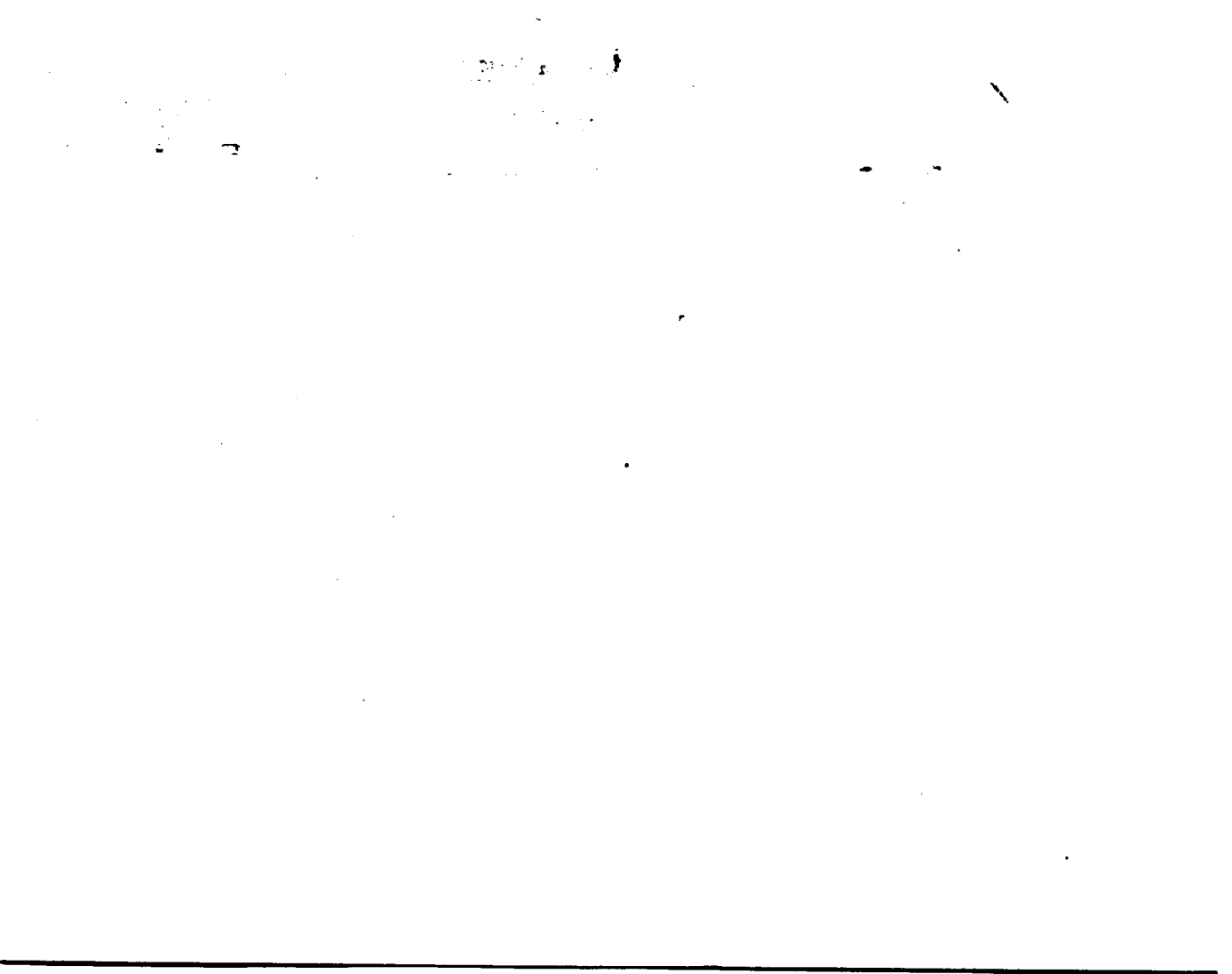
Aberdeen Ida

Filed 6-6 1921

R. T. Noth.

Registrar.

Registrar.





WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.  
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED

CERTIFICATE OF DEATH

34356

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

JUN 9 1921

Registration District No.

County of

Power

BUREAU OF VITAL STATISTICS

Primary Registration District No.

City of

Aberdeen

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ethel Anolia Fenstermaker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Female white

Single  
(Write the word.)

6. DATE OF BIRTH.

May 8 1921  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many hrs. or  
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Meryl E. Fenstermaker

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Jessie Anolia Powell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

M. E. Fenstermaker  
Aberdeen Ida

(Address)

15.

Filed

6-6

1921

R. T. Noble

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 8 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191  
that I last saw him alive on 191  
and that death occurred on the date-stated above, at M.

The CAUSE OF DEATH\* was as follows:

Maternal Eclampsia -  
Still birth

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. C. Markinson M. D.

1921 (Address) Aberdeen - Ida -

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days In the State. yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lutheran Cemetery  
Aberdeen Ida

May 10 1921

20. UNDERTAKER

ADDRESS

Friends

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

315-218-039-695  
PLACE OF BIRTHSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-3-5-17

County of DouglasCity of American Falls

No. .... St.

Hospital Bethany

RECEIVED

JUN 9 1921

BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

File No. ....

Registered No. ....

FULL NAME OF CHILD .....

Sex of Child <u>1 son</u>	Twin Triplet or other? <u>and</u> { Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>5-18-21</u> (Month) (Day) (Year)
---------------------------	--	------------------------	--

FULL NAME <u>Chas. Morris Coufield</u>	FULL MAIDEN NAME <u>Jollie Field</u>
RESIDENCE <u>Amer. Falls, Ida</u>	RESIDENCE <u>Amer. Falls, Ida</u>
COLOR <u>white</u>	COLOR <u>white</u>
AGE AT LAST BIRTHDAY ..... (Years)	AGE AT LAST BIRTHDAY ..... (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Texas</u>
OCCUPATION <u>Retail Merchant</u>	OCCUPATION <u>Housewife</u>

Number of child of this mother, including present birth.... 3 Number of children of this mother now living, including present birth.... 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was ..... at 4:30 P.M. on the date above stated. (Born) Stillborn

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) ..... Richard J. North

Given names added from a supplemental report.

..... 19.....

Registrar

Address..... Amer. Falls, IdaFiled..... 5-18-21 ..... 19.....

Registrar

W.D. 2000-01

WATSON

1994

6. 1992年10月1日以前，在《公司法》施行前，已经依法设立的股份有限公司，其章程符合《公司法》规定的，继续有效。

NAME	DATE	TIME	PLACE	REMARKS
RESIDENCE	DATE	TIME	PLACE	REMARKS
COLOR	DATE	TIME	PLACE	REMARKS
BIRTHPLACE	DATE	TIME	PLACE	REMARKS
OCCUPATION	DATE	TIME	PLACE	REMARKS

STATEMENT OF ATTORNEY PHILIP L. ROBERTS

to conduct a full-scale investigation of the  
activities of the group in the United States and  
to determine if there is any connection between  
the group and the activities of the group in  
the United States.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho  
34354  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23-34354

County of Brown Registration District No. 2372

City of Amer. Falls (No. 3) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Not named

File No. 3

Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white Single (Write in word.)

6. DATE OF BIRTH

3- - 18 1921  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many ..... hrs. or  
..... mins.?

..... yrs. .... mos. .... ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Chas. Morris Canfield

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Zollis Field

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Morris Canfield

(Address)

Amer. Falls, Ida

15.

Filed

6-6

1921

R. T. Voth

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

5- - 18 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw him alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still born  
difficult for exp. delivery  
mother suffering  
from pneumonia  
Contributory (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) Richard F. Voth M. D.  
5-18-1921 (Address) Amer. Falls, Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. .... mos. .... days. In the State yrs. .... mos. .... days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Amer. Falls

5- - 1921

20. UNDERTAKER

ADDRESS

A. H. Davis  
family

Amer. Falls, Ida

152  
A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

795-1011040-296

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-8-8-17

County of Shoshone

MAY 20 1921

CERTIFICATE OF BIRTH

S 91067

City of WallaceBUREAU OF VITAL  
STATISTICS

70

File No. ....

No. 906 Residence

Registration District No. ....

Primary Registration District No. 1011Registered No. 47

Hospital .....

FULL NAME OF CHILD Stuebner

Sex of Child <u>M</u>	Twin Triplet or other? <u>and</u> Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>Feb 1 21</u> (Month) (Day) (Year)
-----------------------	--	------------------------	---

FULL NAME <u>Sidney Stuebner</u>	FATHER
RESIDENCE <u>906 Residence</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Minn</u>	
OCCUPATION <u>Printer</u>	

FULL MAIDEN NAME <u>Harriet A Brown</u>	MOTHER
RESIDENCE <u>906 Residence</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Minn</u>	
OCCUPATION <u>HW</u>	

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stuebner, at 1011 A  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) James R Bean  
(Physician or midwife)

Given names added from a supplemental report.

Address 1011 A  
Apr 2 21  
Registrar F L Jenkins Registrar

RECEIVED

APR 11 1951

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF AGRICULTURE

NAME	ADDRESS	DATE	REMARKS
JOHN J. BENTON	1111 MADISON ST. N.W.	4/11/51	
JOHN J. BENTON	1111 MADISON ST. N.W.	4/11/51	
JOHN J. BENTON	1111 MADISON ST. N.W.	4/11/51	
JOHN J. BENTON	1111 MADISON ST. N.W.	4/11/51	
JOHN J. BENTON	1111 MADISON ST. N.W.	4/11/51	
JOHN J. BENTON	1111 MADISON ST. N.W.	4/11/51	
JOHN J. BENTON	1111 MADISON ST. N.W.	4/11/51	
JOHN J. BENTON	1111 MADISON ST. N.W.	4/11/51	
JOHN J. BENTON	1111 MADISON ST. N.W.	4/11/51	
JOHN J. BENTON	1111 MADISON ST. N.W.	4/11/51	

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

JOHN J. BENTON  
1111 MADISON ST. N.W.  
WASHINGTON, D. C.

APR 11 1951



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 5-15-17.

1. PLACE OF DEATH

County of *Shoshone*

City of *Wallace*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Infant of S. D. Pierce*

CERTIFICATE OF DEATH

Registration District No. *70*

City of *Wallace* Registration District No. *70*

BUREAU OF VITAL STATISTICS

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *33575*  
Registered No. *82575*  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*male*

4. COLOR OR RACE *white*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

*Still born*

(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

*none*

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*S. D. Pierce*

11. BIRTHPLACE OF FATHER

(State or Country)

*Idaho*

12. MAIDEN NAME OF MOTHER

*Harriet A. Brown*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*S. D. Pierce*  
*906 Riverside St.*  
*Wallace, Idaho*

15.

Filed

*Feb 21 1921*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Stillborn Feb 1<sup>st</sup>*

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. . . . . alive on 191 and that death occurred on the date stated above, at 10.15 A.M.

The CAUSE OF DEATH\* was as follows:

*Still born*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) *James R. Dean* M. D.

1921 (Address) *Wallace*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death . . . . . yrs. . . . . mos. . . . . days. In the State . . . . . yrs. . . . . mos. . . . . days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

*Wallace, Ida*

DATE OF BURIAL

*Feb 1. 1921*

20. UNDERTAKER

*B. E. Norstell*

ADDRESS

*Wallace*

1893

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

683205-080-417

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Shoshone RECEIVED  
MAY 20 1921

CERTIFICATE OF BIRTH

S 91076

City of Malce

Registration District No. 70

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. STAI

Primary Registration District No. 1011

Registered No. 56

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Miss Okler

Sex of Child <u>7</u>	Twin Triplet or other? <u>and</u>	Number in order of birth	Legitimate? <u>7</u>	Date of Birth <u>4</u> <u>5</u> <u>21</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

FATHER  
FULL NAME John Okler  
RESIDENCE Malce  
COLOR W AGE AT LAST BIRTHDAY 44 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Miner

MOTHER  
FULL MAIDEN NAME Emma Maxwell  
RESIDENCE Malce  
COLOR W AGE AT LAST BIRTHDAY 34 (Years)  
BIRTHPLACE Weiser Idaho  
OCCUPATION Housewife

Number of child of this mother, including present birth 8 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Shelton, at 2:30 P. M. on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. W. A. Brown

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Boise Idaho

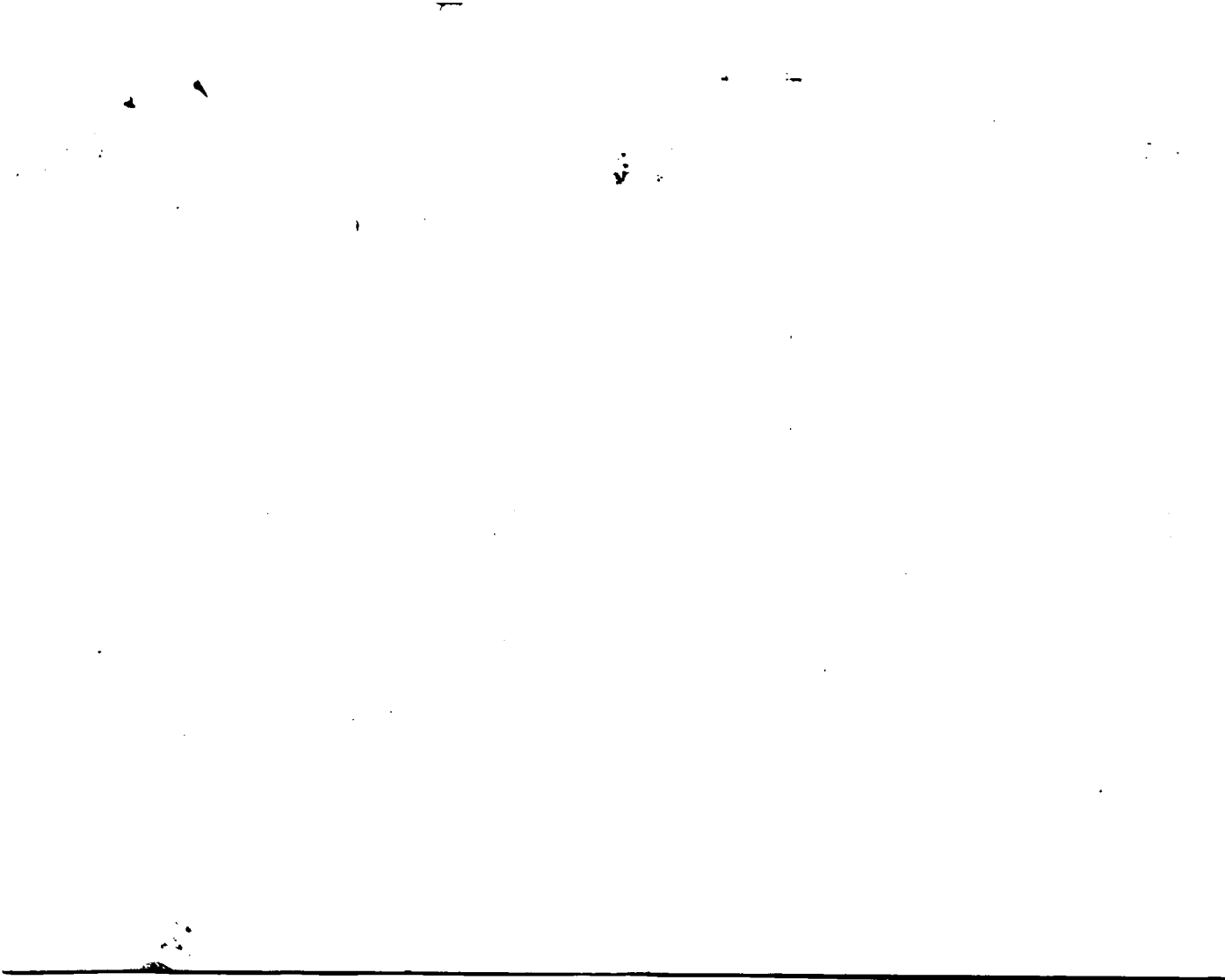
Apr 10

19 21

G. L. Jenkins

Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 34367  
Registered No. 22

1. PLACE OF DEATH. Shoshone District No. 70  
County of Shoshone Registration District No. 1611  
City of Malce (No. 1611 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Miss Ohler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single  
(Write the word.)

6. DATE OF BIRTH 4 5 1921  
(Month) (Day) (Year)

7. AGE — yrs. — mos. — ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION  
(a) Trade, profession or particular kind of work. None  
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Malce  
(State or Country)

10. NAME OF FATHER John Ohler

11. BIRTHPLACE OF FATHER Idaho  
(State or Country)

12. MAIDEN NAME OF MOTHER Emma Maxwell

13. BIRTHPLACE OF MOTHER Idaho  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Emma Ohler  
(Address) Malce Ida

15. Apr 5 1921 F. L. Jackson  
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 4 5 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 5 1921, to Apr 5 1921  
that I last saw h. — alive on — 1921  
and that death occurred on the date stated above, at 2:30 P.M.  
The CAUSE OF DEATH\* was as follows:  
Stroke

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.  
(Signed) Chas. A. Deane M. D.  
Apr 5 1921 (Address) Malce Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.  
Where was disease contracted,  
If not at place of death?  
Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho DATE OF BURIAL Apr 5 1921

20. UNDERTAKER Father ADDRESS Malce Ida

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

168-018-046-719

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Washington

JUN 9 1921

CERTIFICATE OF BIRTH

City of Weiser

BUREAU OF VITAL  
STATISTICS

Registration District No. 76

File No.

S 91252

No. \_\_\_\_\_ St.

Primary Registration District No. 2/12

Registered No. 77

FULL NAME OF CHILD

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate? <u>yes</u>	Date of Birth <u>4</u> <u>18</u> <u>1921</u> (Month) (Day) (Year)
--------------	---	-----	---	-------------------------------	--

FATHER

FULL NAME Theodore Johnson

RESIDENCE Wilder Idaho

COLOR White AGE AT LAST BIRTHDAY 22 (Years)

BIRTHPLACE Chicago Illinois

OCCUPATION Farmer

MOTHER

FULL MAIDEN NAME Margaret Parks

RESIDENCE Wilder Idaho

COLOR White AGE AT LAST BIRTHDAY 22 (Years)

BIRTHPLACE Cambridge Ida

OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 11:30 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Ernest O. Finney  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

19

Address W R Hamilton  
Filed June 1st 1921  
Registrar

Registrar

ND



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

296227.044-812

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Washington

RECEIVED

JUN 9 1921

CERTIFICATE OF BIRTH

City of Weiser

BUREAU OF VITAL  
STATISTICS

86

File No.

S 91254

No. St.

Primary Registration District No. 2112

Registered No. 79

FULL NAME OF CHILD

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate? <u>yes</u>	Date of Birth <u>4 23 1921</u> (Month) (Day) (Year)
----------------------------	---	-----	---	----------------------------	---

FULL NAME <u>Levi Broadbent</u>	FATHER
RESIDENCE <u>Weiser Idaho.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>48</u> (Years)
BIRTHPLACE <u>Wellsville Utah</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Bettie Haslam</u>	MOTHER
RESIDENCE <u>Weiser Idaho.</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)
BIRTHPLACE <u>Wellsville Utah</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 13 Number of children of this mother now living, including present birth 11

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 830 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Orval O. Finney  
(Physician or midwife)

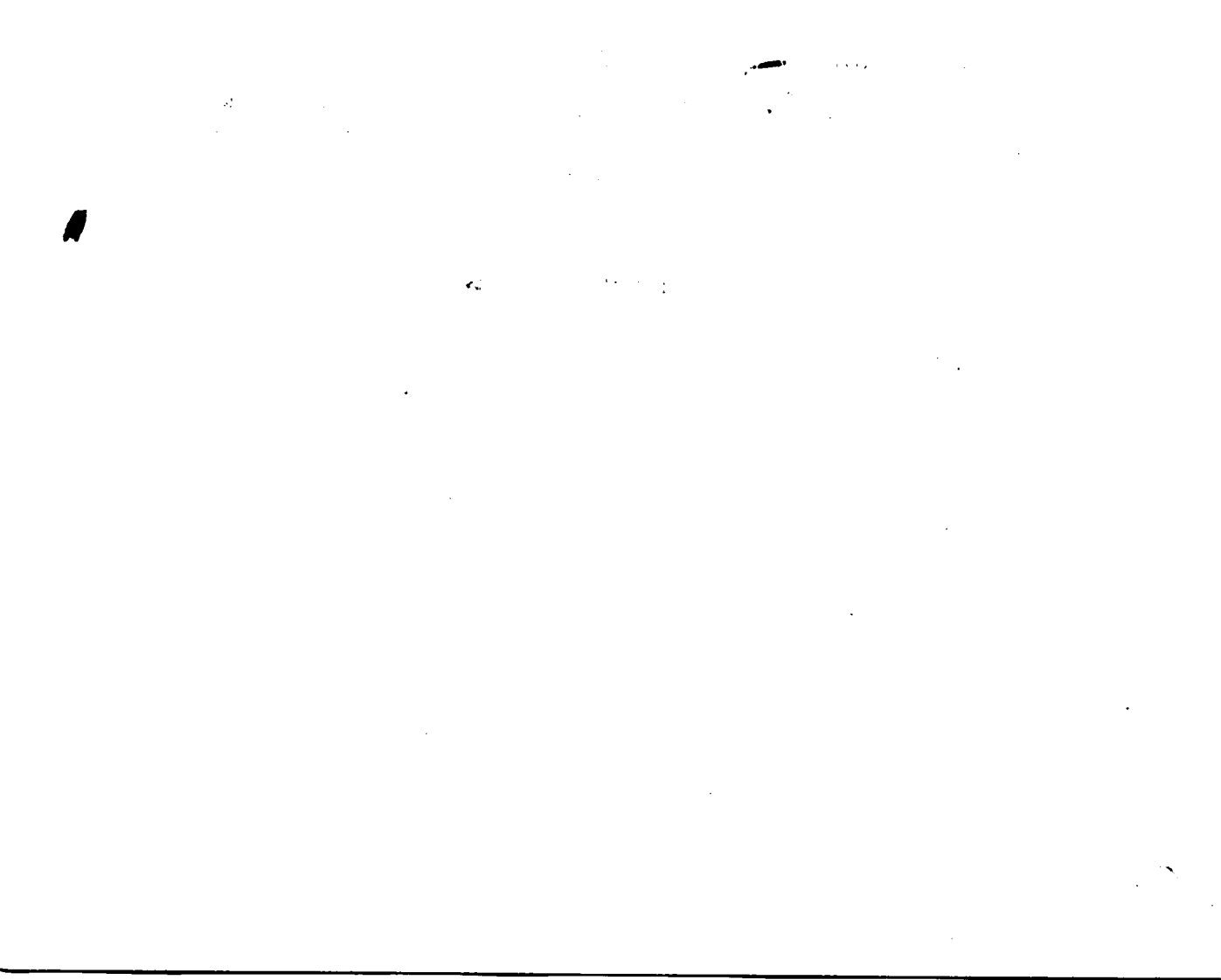
Given names added from a supplemental report.

19

Address

Filed June 1st 1921 W R Hamblin  
Registrar

Registrar



WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

266-225-044-356

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

County of WashingtonCity of Wash.

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
RECEIVED  
JUN 9 1921  
BUREAU OF VITAL  
STATISTICS  
86

File No. \_\_\_\_\_

Primary Registration District No. 2112 Registered No. 81

S 91256

## FULL NAME OF CHILD

Sex of Child Female Twin Triplet } and { Number in order of birth } Legiti mate? Yes Date of Birth April 25 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME James E. Brown  
RESIDENCE Wash. Id.  
COLOR White AGE AT LAST BIRTHDAY 31 (Years)  
BIRTHPLACE I. Dakota  
OCCUPATION Blacksmith

MOTHER  
FULL MAIDEN NAME Melissa M. Leonard  
RESIDENCE Wash. Id.  
COLOR White AGE AT LAST BIRTHDAY 29 (Years)  
BIRTHPLACE Indiana  
OCCUPATION House wife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born at 1:45 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. P. Staunton M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address \_\_\_\_\_

Filed May 15 1921 M. P. Staunton

Registrar

Registrar



266401

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of

CERTIFICATE OF BIRTH

City of

BUREAU OF VITAL  
STATISTICS

Registration District No.

File No.

No.

St.

Primary Registration District No.

Registered No.

Hospital

FULL NAME OF CHILD

Sex of  
Child

Male

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti  
mate?

Yes

Date of  
Birth

4 1 1921

(Month)

(Day)

(Year)

FULL  
NAME

FATHER

Thomas R. Bowlder

FULL  
MAIDEN  
NAME

MOTHER

Emma E. Taylor

RESIDENCE

Gannett, Ida

RESIDENCE

Gannett, Ida

COLOR

white

AGE AT LAST  
BIRTHDAY27  
(Years)

COLOR

white

AGE AT LAST  
BIRTHDAY25  
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Utah

OCCUPATION

Farmer

OCCUPATION

Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
born alive or stillborn.

Stillborn at 8 A. M.

(If no attending physician or

midwife  
should  
one that  
dence of the

Robert H. Wright - M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Hailey, Ida

Filed

4-11-21 R. H. Wright

Registrar

Registrar

GIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
In case of one child at birth a SEPARATE RETURN must be made for each  
the number of each, in order of birth stated.

N. B.—In case of



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Blaine  
County of Blaine  
City of Gannett  
Registration District No. 57  
Registration District No. 2022  
St.)

File No. 34126  
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Bowlden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male wht. (Write the word.)

## 6. DATE OF BIRTH

Apr 1 21  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

Steelbom

## 9. BIRTHPLACE

(State or Country)

Gannett, Ida

## 10. NAME OF FATHER

Thomas R. Bowlden

## 11. BIRTHPLACE OF FATHER

(State or Country)

Utah

## 12. MAIDEN NAME OF MOTHER

Emma E. Taylor

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas R. Bowlden  
(Address) Gannett, Ida

15. Filled 4-11-21 R. N. Wright

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Apr 1 21  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19  
that I last saw h. alive on 19  
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Steelbom

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Phert H. Wright M. D.

#-1-19-21 (Address) Hailey, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Gannett

## DATE OF BURIAL

4-21-21

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



485-219-001-719

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C—25m-9-8-15

County of Ada

## CERTIFICATE OF BIRTH

City of BoiseRegistration District No. 2File No. **S 91302**

No. \_\_\_\_\_ St.

Primary Registration District No. 1004Registered No. 256Hospital St. LukesFULL NAME OF CHILD OyesSex of Child F.Twin  
Triplet  
or other?and { Number  
in order  
of birthLegiti-  
mate? YesDate of Birth May 19 1921

(Month) (Day) (Year)

FULL NAME

FATHER

FULL MAIDEN NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR WAGE AT LAST BIRTHDAY 26

(Years)

COLOR WAGE AT LAST BIRTHDAY 25

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth. 3Number of children of this mother now living, including present birth. 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE \*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated.

(Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Edward H. King M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address \_\_\_\_\_

Filed June 13 1921

Registrar

Registrar R. H. Packer

6

12

4

12

## 1. PLACE OF DEATH

County of Adair  
City of BoiseRECEIVED  
JUN 3 1921BUREAU OF VITAL  
STATISTICS

## CERTIFICATE OF DEATH

Registration District No. 1Registration District No. 104City of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant DyerState of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 34037Registered No. 748

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

M

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

May 19 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).None

## 9. BIRTHPLACE

(State or Country)

Boise Idaho

## 10. NAME OF FATHER

Earnest Dyer

## 11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

## 12. MAIDEN NAME OF MOTHER

Ollie Garrett

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Howard McPhail(Address) 1501 N 26 St

## 15.

Filed May 19 1921

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 19 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

May 19 1921 to May 14 1921  
that I last saw her alive on May 14 1921and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still birth

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Edw. H. Hays M.D.(Address) Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Morris Hiscenbury May 20 1921

## 20. UNDERTAKER

## ADDRESS

Dunsmuir & Krebs Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

913-220-001-395

PLACE OF BIRTH

County of AdaCity of BoiseNo. P.R. 4 St.

Hospital

Full Name of Child not named

RECEIVED

RECEIVED JUL 5 1921

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11—25m-6-16-18

Registration District No. 8Primary Registration District No. 2004S  
File No. 91337Registered No. 76

SEX OF CHILD <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	Number in order of birth { and }	Legiti- mate? <u>yes</u>	DATE OF BIRTH <u>5 20 21</u> (Month) (Day) (Year)
FULL NAME <u>Joseph Ratliffe</u>	FATHER		FULL MAIDEN NAME <u>Flora Lindall</u>	MOTHER
RESIDENCE <u>Boise R 4</u>			RESIDENCE <u>Boise</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY	(Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY
BIRTHPLACE <u>Texas</u>			BIRTHPLACE <u>Penn</u>	
OCCUPATION <u>farmer</u>			OCCUPATION <u>housewife</u>	

Number of child of this mother, including present birth..... Number of children of this mother now living, including present birth.....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born (Born alive or stillborn), at..... M on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) N. G. Raaf

(Physician or midwife)

Given names added from a supplemental report.

19.....

Address

Filed

June 13, 1921

Registrar

Registrar



FORM V. S. No. 5-A--25 M. 1-19.

**RECEIVED**

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Ada  
City of Meridian**JUN 9 1921****BUREAU OF VITAL STATISTICS**

Registration District No. ....

Registration District No. 11

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stitt BornState of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 34046  
Registered No. 92

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

6. DATE OF BIRTH

May 20 1921  
(Month) (Day) (Year)

7. AGE

Stitt BornIF LESS than 1 day  
how many..... hrs.  
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).None

9. BIRTHPLACE

(State or Country)

Ada county Idaho

10. NAME OF FATHER

Joseph Ratliff

11. BIRTHPLACE OF FATHER

(State or Country)

Bethel Texas

12. MAIDEN NAME OF MOTHER

Gloze Tindall

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joe Ratliff  
Born R. H. P. now

15.

Filed 5-20 1921H. F. Neal  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 20 1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 20 1921, to May 20 1921, that I last saw him alive on Sept 23 19, and that death occurred on the date stated above, at 5:20 M.  
The CAUSE OF DEATH was as follows:  
Stitt Born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. F. Neal M. D.5-20-1921 (Address) Meridian, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian, Idaho May 20 1921

20. UNDERTAKER

ADDRESS

W. B. Metter Meridian

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



962-117-017-612  
PLACE OF BIRTH

RECEIVED  
JUL 10 1921

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-8-15

County of Clark

City of Humphrey

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital Nurse

FULL NAME OF CHILD No Name - still born.

BUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

S 91518

Registration District No. 125

File No. \_\_\_\_\_

Primary Registration District No. 2203

Registered No. \_\_\_\_\_

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>6</u> <u>17</u> <u>1921</u> (Month) (Day) (Year)
--------------------------	--	------------------------------	------------------------	--

FULL NAME F. Otto Robbers  
FATHER  
RESIDENCE Humphrey  
COLOR white  
AGE AT LAST BIRTHDAY 36  
(Years)  
BIRTHPLACE Idaho  
OCCUPATION Farmer

FULL MAIDEN NAME Ada B. Wakefield  
MOTHER  
RESIDENCE Humphrey  
COLOR white  
AGE AT LAST BIRTHDAY 43  
(Years)  
BIRTHPLACE Iowa  
OCCUPATION Housewife

Number of child of this mother, including present birth 7

Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE \*

I hereby certify that I attended the birth of this child, who was still born, at 3 P. M. on the date above stated.  
(Born alive or stillborn)

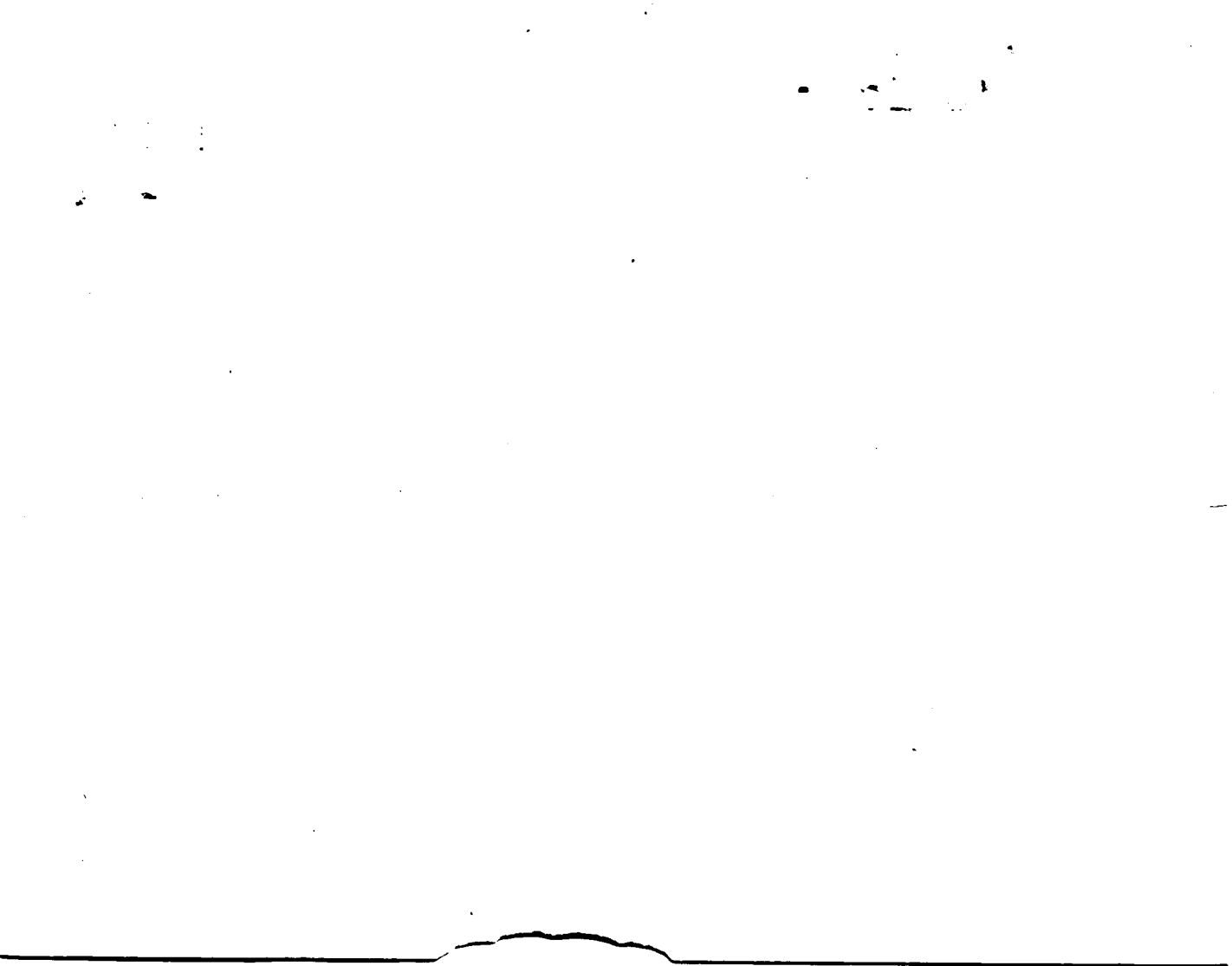
\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) A. H. Jones  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Subair Idaho

Filed June 18 1921 W. E. Jones M.D.  
Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		RECEIVED JUL 10 1921 BUREAU OF VITAL STATISTICS		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH		Registration District No. 155		Registration District No. 2203		File No. 34513	
County of Clark		City of Humphrey (No. , St.)		Registered No.		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME No Name					
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3. SEX Male		4. COLOR OR RACE White		5. SINGLE, MARRIED, WIDOWED OR DIVORCED.		16. DATE OF DEATH	
		(Write the word.)				6 17 1921 (Month) (Day) (Year)	
6. DATE OF BIRTH				17. I HEREBY CERTIFY, That I attended deceased from			
6 17 1921 (Month) (Day) (Year)				191., to 191.,			
7. AGE Still born				that I last saw h..... alive on 191.,			
IF LESS than 1 day how many hrs. or mins.?				and that death occurred on the date stated above, at M.			
7 yrs. 7 mos. ds.				The CAUSE OF DEATH* was as follows:			
8. OCCUPATION				Still born			
(a) Trade, profession or particular kind of work				7 mos			
(b) General nature of industry, business, or establishment in which employed (or employer)				(Duration) yrs. mos. ds.			
9. BIRTHPLACE				Contributory			
(State or Country) Humphrey Idaho				(Secondary)			
10. NAME OF FATHER J. Otto Robbins				(Duration) yrs. mos. ds.			
11. BIRTHPLACE OF FATHER Idaho				(Signed) A. H. Jones			
(State or Country)				June 18 1921 (Address) Subito Idaho			
12. MAIDEN NAME OF MOTHER Ada B Wakefield				State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.			
13. BIRTHPLACE OF MOTHER Iowa				18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)			
(State or Country)				At place of death yrs. mos. days. In the State yrs. mos. days.			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				Where was disease contracted if not at place of death?			
(Informant) J. Otto Robbins				Former or usual residence			
(Address) Humphrey Idaho				19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL			
15. Filed June 18 1921				Humphrey Idaho 6/18 1921			
Local Registrar				20. UNDERTAKER ADDRESS			
				none			

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

1893

851-2181028-255  
PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

RECEIVED  
JUN 25 1921

CERTIFICATE OF BIRTH

S 91636

County of Kootenai

City of Harrison

BUREAU OF VITAL  
STATISTICS 26

File No. 5

No. \_\_\_\_\_ St.

Primary Registration District No. 2204

Registered No. 34

Hospital \_\_\_\_\_

FULL NAME OF CHILD (No name)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of Birth <u>May 18 1921</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------------	--

FATHER  
FULL NAME Erick Bradlund  
RESIDENCE Harrison Ida  
COLOR White AGE AT LAST BIRTHDAY 28  
(Years)  
BIRTHPLACE Sweden  
OCCUPATION Rancher

MOTHER  
FULL MAIDEN NAME Christina Benson  
RESIDENCE Harrison Ida  
COLOR White AGE AT LAST BIRTHDAY 42  
(Years)  
BIRTHPLACE Sweden  
OCCUPATION Housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

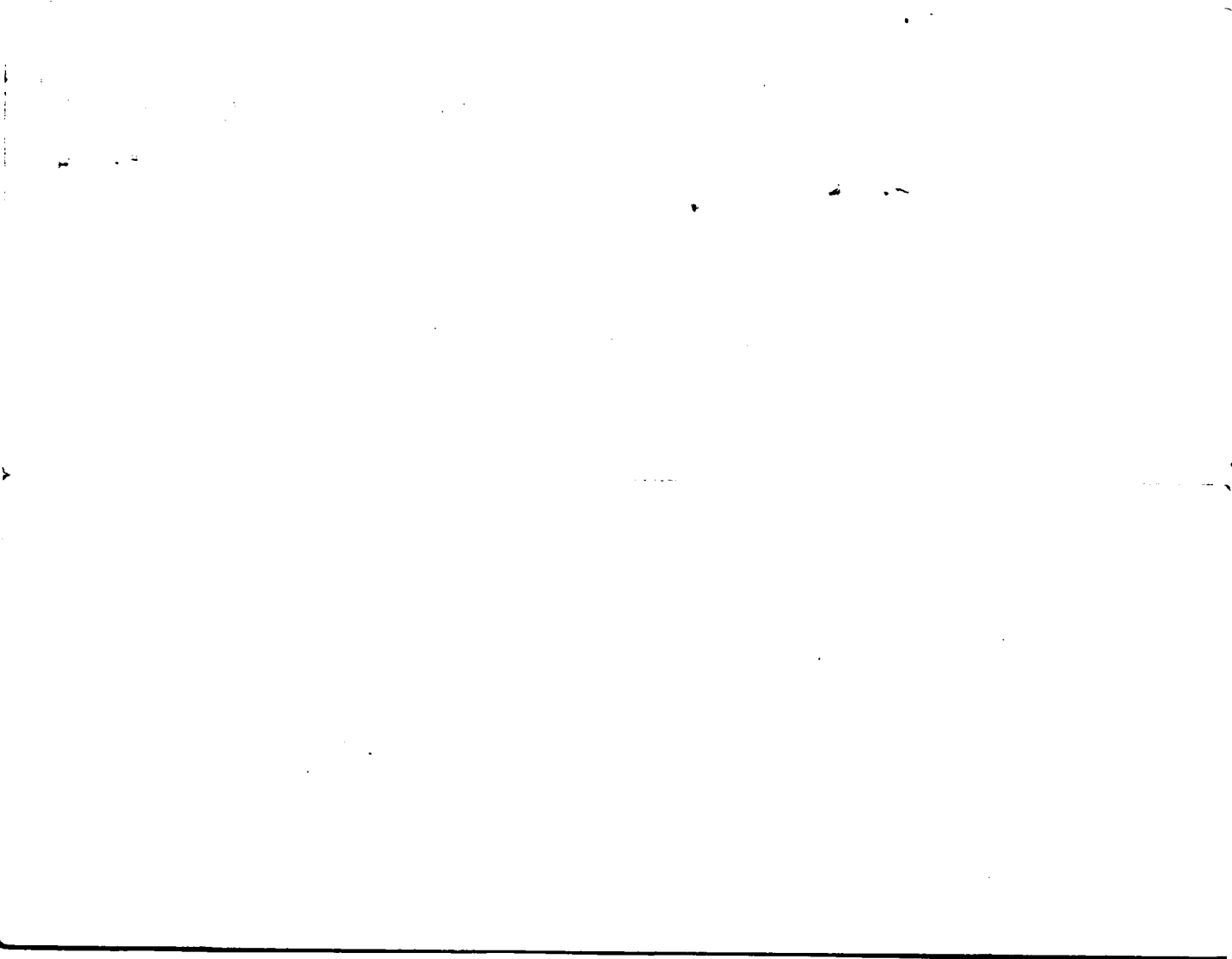
I hereby certify that I attended the birth of this child, who was Still born May 18-21 at 3a M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mrs. C. W. Ward  
Midwife  
(Physician or midwife)

Given names added from a supplemental report.

Address Harrison Ida  
Date June 1 1921 M. W. Trimmer  
Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

34552 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

County of Kootenai  
City of Harrison

RECEIVED

Registration District No. 126  
JUN 25 1921  
Registration District No. 2204File No. 9  
Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

BUREAU OF VITAL  
STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female Whitesingle  
(Write the word.)

## 6. DATE OF BIRTH.

..... 1 .....  
(Month) (Day) (Year)

## 7. AGE

..... Yrs. .... Mos. .... ds.

IF LESS than 1 day  
how many ..... hrs. or  
..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

Erick Hadlund

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

Cheshire Benson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

E Hadlund  
Harrison Ida

## 15.

Filed

6-1

1921

Local Registrar

## 16. DATE OF DEATH

May 18 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

191..... to 191.....

that I last saw him alive on 191.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

Sill Bone

(Duration) Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) Yrs. .... mos. .... ds.

(Signed) J. H. Benson M. D.5-18-21 (Address) Harrison Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SURGICAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. .... mos. .... days In the State..... yrs. .... mos. .... days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

191.....

## 20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

1891  
10



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

385-102.035-363

PLACE OF BIRTH

BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

S91850

County of Wyz Pover

RECEIVED

CERTIFICATE OF BIRTH

City of Lummit

1915

Registration District No. 92

File No. 9

No. \_\_\_\_\_

BUREAU OF VITAL STATISTICS

Primary Registration District No. 2170

Registered No. 11

Hospital \_\_\_\_\_

FULL NAME OF CHILD Infant Cheuvrouh

Sex of Child <u>M.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate? <u>yes</u>	Date of Birth <u>7</u> <u>2</u> <u>1921</u> (Month) (Day) (Year)
------------------------	---	-----	---	-------------------------------	--

FATHER  
FULL NAME S. L. Cheuvrouh  
RESIDENCE Lummit  
COLOR Wh AGE AT LAST BIRTHDAY 43 (Years)  
BIRTHPLACE Mo  
OCCUPATION farmer

MOTHER  
FULL MAIDEN NAME Beretta Collins  
RESIDENCE Lummit  
COLOR Wh AGE AT LAST BIRTHDAY 40 (Years)  
BIRTHPLACE Wh War  
OCCUPATION house

Number of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 9 a M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. E. Watts

(Physician ~~or midwife~~)

Given names added from a supplemental report.

Address \_\_\_\_\_  
Filed 7-2 1921 E. E. Watts  
Registrar

Registrar



STILLBORN

Dup of 1921-92662

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

## CERTIFICATE OF DEATH

34594

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Nez Perce*  
City of *Lewiston*Registration District No. *92*BUREAU OF VITAL STATISTICS  
Primary Registration District No. *2170*  
(No. \_\_\_\_\_ St.)File No. *5*Registered No. *26*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Infant Churrough*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*M*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*single*  
(Write the word.)

6. DATE OF BIRTH.

*7* *2* *1921*  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

*S. L. Churrough*

11. BIRTHPLACE OF FATHER

(State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER

*Corretta Collins*

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*S. L. Churrough*

(Address)

*Lewiston*

15.

Filed *7-2* *1921**E. E. Thatt*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*7* *2* *1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191  
that I last saw him alive on 191  
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH\* was as follows:

*still born -  
premature*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. E. Thatt* M. D.7-2-1921 (Address) *Lewiston*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

*Lewiston Idaho*

DATE OF BURIAL

*7-3* *1921*

20. UNDERTAKER

*W. E. Stoddard*

ADDRESS

*Lewiston*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

1879

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

493-130-035-268

PLACE OF BIRTH

County of my Perce

City of Gifford

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
**RECEIVED**  
**JUL 5 1921**  
BUREAU OF VITAL STATISTICS

Primary Registration District No. 2170

Form V. S. No. 11-C-25m-7-21-19

**S 91852**

File No. 9

Registered No. 10

Sex of Child <u>M</u>	Twin Triplet or other? <u>  </u> and <u>  </u> Number in order of birth <u>  </u>	Legitimate? <u>yes</u>	Date of Birth <u>6</u> <u>30</u> <u>1921</u> (Month) (Day) (Year)
-----------------------	---	------------------------	--

FATHER  
FULL NAME Wm J. Dickhoff  
RESIDENCE Gifford  
COLOR Wh AGE AT LAST BIRTHDAY 46  
(Years)  
BIRTHPLACE Ill  
OCCUPATION farmer

MOTHER  
FULL MAIDEN NAME Luiz Boyd  
RESIDENCE Gifford  
COLOR Wh AGE AT LAST BIRTHDAY 25  
(Years)  
BIRTHPLACE mo  
OCCUPATION house

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born, at 4 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. E. Watts

(Physician or midwife)

Given names added from a supplemental report.

19

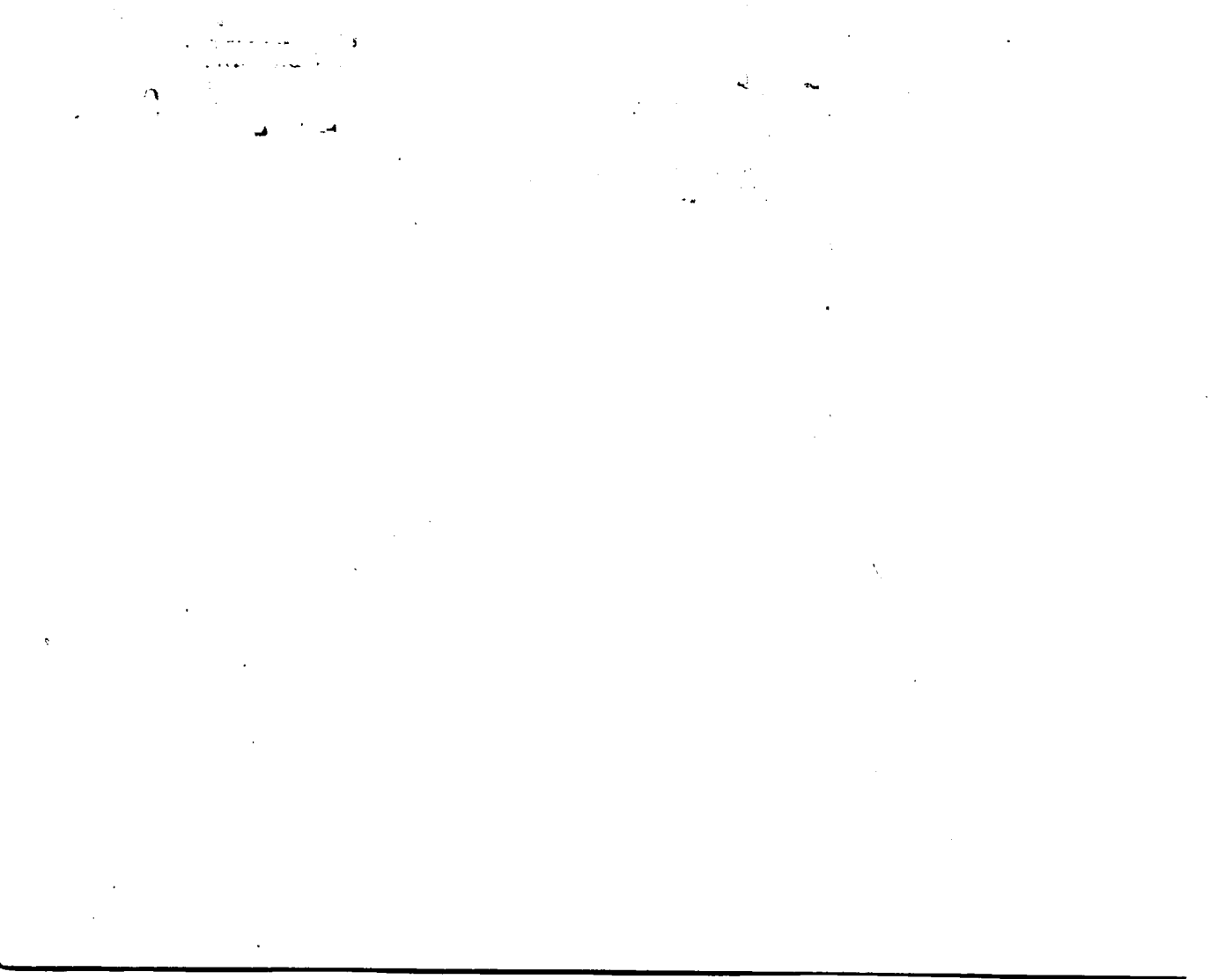
Address \_\_\_\_\_

Filed 6-30 1921

E. E. Watts

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

34593 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 6  
Registered No. 24

1. PLACE OF DEATH.

County of *My Perce*  
City of *Efford*  
Registration District No. *92*  
Registration District No. *2170*  
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Infant Dietrichhoff*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX

*m*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*single*  
(Write the word.)

6. DATE OF BIRTH.

*June 30 1921*  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

*none*

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*Wm. J. Dietrichhoff*

11. BIRTHPLACE OF FATHER

(State or Country)

*Idaho*

12. MAIDEN NAME OF MOTHER

*Luz Boyd*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Mo*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

*Wm. J. Dietrichhoff*  
*Efford Idaho*

(Address)

15.

Filed

*6-30**1921**E. E. Watts*

Local Registrar

16. DATE OF DEATH

*6 30 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at *4 P* M.

The CAUSE OF DEATH\* was as follows:

*still born*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

*E. E. Watts*

M. D.

*6-30-1921* (Address) *Efford*

\*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL

*German Cem*

DATE OF BURIAL

*7-1 1921*

20. UNDERTAKER

*W. B. Boyd (act)*

ADDRESS

*Efford*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

169



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

847214-001-331  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S 91945**

RECEIVED  
County of Blaine  
**AUG 13 1927**  
BUREAU OF VITAL  
STATISTICS

Registration District No. C File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_  
(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>June 14</u> 192 <u>7</u> (Month) (Day) (Year)
-----------------------	---	-------	--------------------------------	-----------------------------	--

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth. \_\_\_\_\_ Number of child of this mother now living, including present birth. \_\_\_\_\_

FULL NAME <u>William Joseph Haghe</u>	FATHER	FULL MAIDEN NAME <u>Effie Nora Clarke</u>	MOTHER
---------------------------------------	--------	---	--------

RESIDENCE <u>Star</u>	RESIDENCE <u>Star</u>
-----------------------	-----------------------

COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)
----------------	--	----------------	--

BIRTHPLACE <u>Missouri</u>	BIRTHPLACE <u>Idaho</u>
----------------------------	-------------------------

OCCUPATION <u>Machinist</u>	OCCUPATION <u>H. wife</u>
-----------------------------	---------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Clifford H. H. H.

Give names added from a supplemental report.

Address Star Idaho

Filed Aug 13 1927 Ernie K. Turner  
Registrar.

Registrar.

STATE OF OHIO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH  
2 9 4 4 5

Registration District No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

Full Name of Child

Sex of Child \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Place of Birth \_\_\_\_\_

Full Name of Mother \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Place of Birth \_\_\_\_\_

Full Name of Father \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Place of Birth \_\_\_\_\_

Age at Last Birthday \_\_\_\_\_  
Age at Last \_\_\_\_\_

Marriage \_\_\_\_\_  
Marriage \_\_\_\_\_

Occupation \_\_\_\_\_  
Occupation \_\_\_\_\_

Certificate of Attending \_\_\_\_\_  
Certificate of Attending \_\_\_\_\_

Signature of Registrar \_\_\_\_\_  
Signature of Registrar \_\_\_\_\_

Signature of \_\_\_\_\_  
Signature of \_\_\_\_\_

Signature of \_\_\_\_\_  
Signature of \_\_\_\_\_

ON

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

219-118-003-795

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH  
County of Bannock  
City of McCammon, Ida.  
Registration District No. 28  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Primary Registration District No. 2161  
Hospital \_\_\_\_\_  
Registered No. 3892  
FULL NAME OF CHILD no name, prematurely born.

STATE OF IDAHO  
RECEIVED  
AUG 10 1921  
BUREAU OF VITAL STATISTICS  
S 81959

Sex of Child male Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legiti mate? yes Date of Birth July 18 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Gerald R. Bair</u>	<u>Tacoma Nev.</u>	<u>Sarah Elizabeth Green</u>	<u>Tacoma, Nev.</u>
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Utah</u>		BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Signal Maintainer</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth. 4 Number of children of this mother now living, including present birth. 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  
I hereby certify that I attended the birth of this child, who was stillborn, at 5:30 P.M. on the date above stated.  
(Born alive or stillborn)  
{ \*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }  
Given names added from a supplemental report. \_\_\_\_\_  
19\_\_\_\_\_  
Registrar \_\_\_\_\_  
(Signature) Wilson J. McDill  
Phys. & Surg.  
(Physician or midwife)  
Address McCammon  
Filed 8/1 19 21  
Registrar W. Young

...the ... of ...

As a result of this, the Government of the United States has decided to take the following action:

CHRIS DAVIS - 2-11-68 H. W. ...

STATE OF NEW YORK  
IN SENATE  
JANUARY 11, 1911.

2142

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

100

Primary Registration District No. 14 Registered No. 14

# LetigenH

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

[illegible][illegible]

RESIDENCE  
TWOEY, NEV.      RESIDENCE  
TWOEY, NEV.

[illegible]

IDENTIFICATION

OCCUPATION  
Hennepin

OCCUPATION  
St. Louis

**SECRET**

1. I hereby certify that I attended the trial of the said wife and

(REDACTED)

**SECRET**

**SECRET**

115 22 11/1/55 SOUTH

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

318-202-003-318

PLACE OF BIRTH

County of Bannock

City of Hawkins

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

FULL NAME OF CHILD Maybelle Taylor

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
RECEIVED  
AUG 10 1921  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S 91982

Register 28  
BUREAU OF VITAL  
STATISTICS

File No. 73

Primary Registration District No. 1141

Registered No. 3870

Sex of Child <u>girl</u>	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimacy yes	Date of Birth <u>July 2</u> 19 <u>21</u> (Month) (Day) (Year)
--------------------------	--	-----	--------------------------------	-------------------	--

FATHER  
FULL NAME Wilford Taylor  
RESIDENCE Hawkins, Ida.  
COLOR white AGE AT LAST BIRTHDAY 27  
(Years)  
BIRTHPLACE Idaho  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Charlotte Taylor  
RESIDENCE Hawkins, Ida  
COLOR white AGE AT LAST BIRTHDAY 21  
(Years)  
BIRTHPLACE Utah  
OCCUPATION Housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 2:50 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) William J. M. Dill  
Phys. & Surg.  
(Physician or midwife)

Given names added from a supplemental report.

Address 111 1/2 1st  
Filed 11 19 21  
Registrar J. H. Hanning

Registrar



ERVED FOR BINDING

ADINK THIS IS A PERMANENT RECORD

one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH  
884-212-904-253

County of Blaine Lake

City of Liberty

No. .... St.

Hospital .....

FULL NAME OF CHILD Still Born

Sex of Child <u>Female</u>	Twin Triplet or other? <u>X</u> and <u>X</u> in order of birth <u>X</u>	Legitimate? <u>yes</u>	Date of Birth <u>6</u> <u>12</u> <u>1913</u> (Month) (Day) (Year)
----------------------------	---	------------------------	--

FATHER  
FULL NAME Malvin W Hyman  
RESIDENCE Liberty  
COLOR White AGE AT LAST BIRTHDAY 27 (Years)  
BIRTHPLACE Liberty Idaho  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Selvia Peterson  
RESIDENCE Liberty  
COLOR White AGE AT LAST BIRTHDAY 26 (Years)  
BIRTHPLACE Idaho  
OCCUPATION House Wife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ..... at .....  
he date above stated.

\*When there was no attending physician or twice then the father, householder, etc., should this return. A stillborn child is one that er breathes nor shows other evidence of life at birth.

(Signature) Still Born at 10:30 P.M.  
Still Born  
(Physician or midwife)

Given names added from a supplemental report.

Address .....  
19.....  
Registrar

Filed July 10 1921 Mrs. J. S. Hemmerson  
Registrar

STATE OF IDAHO Form V. S. No. 11-0-22-0-17

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 92002

File No. 28

BUREAU OF VITAL STATISTICS

Primary Registration District No. ....

Registered No. ....

CV



8V6 223004-753  
 PLACE OF BIRTH

 STATE OF IDAHO  
 DEPARTMENT OF PUBLIC WELFARE  
 RECEIVED  
 BUREAU OF VITAL STATISTICS
County of BlaineCity of MontpelierRegistration District No. 32

File No.

S 92010

No. \_\_\_\_\_ St.

Primary Registration District No. 2136

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD Girl Helen General HuffSex of Child GirlTwin  
Triplet  
or other?  
(To be answered only in event of plural births)and { Number  
of birthLegiti-  
mate? yesDate of  
Birth  
(Month) (Day) (Year)May 23, 1921FULL  
NAME

FATHER

Stanley Huff

RESIDENCE

Montpelier

COLOR

WhiteAGE AT LAST  
BIRTHDAY31  
(Years)

BIRTHPLACE

Nebraska

OCCUPATION

LaborerFULL  
MAIDEN  
NAME

MOTHER

Helen Peterson

RESIDENCE

Montpelier

COLOR

WhiteAGE AT LAST  
BIRTHDAY32  
(Years)

BIRTHPLACE

Mink Creek

OCCUPATION

HousekeepingNumber of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at BIBD A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Charles E. Hunkley

(Physician or midwife)

Given names added from a supplemental report.

Address Montpelier, IdaFiled 8-1-19 21

Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

100

100

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

## BUREAU OF VITAL STATISTICS.

Place of Birth { City Montpelier  
 Street Jefferson Street  
 County Bear Lake

File Number 92010

Registration Dist. No. ....

Sex of Child girl

Date of Birth May 23, 1921

Father Female Full Name

Mother Helen Elenora Petersen Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Helen Geneal Huff  
 Child's Name in Full

Mrs. Helen Elenora Huff  
 Signature of Father or Mother

4.

MD

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

249227.00219  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Bear Lake RECEIVED AUG 10 1921

City of Georgetown BUREAU OF VITAL STATISTICS

S 92014

No. \_\_\_\_\_ St. \_\_\_\_\_

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2136

Registered No. \_\_\_\_\_

FULL NAME OF CHILD Girl

Sex of Child <u>Girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of Birth (Month) <u>May</u> (Day) <u>27</u> (Year) <u>1921</u>
--------------------------	---	-----	--------------------------------	-----------------------------	---

FATHER FULL NAME <u>E. M. Smith</u>
RESIDENCE <u>Georgetown</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Berlington</u>
OCCUPATION <u>Farming</u>

MOTHER FULL MAIDEN NAME <u>Esther Band</u>
RESIDENCE <u>Georgetown</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Minkcreek</u>
OCCUPATION <u>Housekeeping</u>

Number of child of this mother, including present birth 8 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 5 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Elmer Estlinley  
(Physician or midwife)

Given names added from a supplemental report. \_\_\_\_\_ 19. \_\_\_\_\_

Address Edmont, Idaho  
Filed 8-1-21 19. \_\_\_\_\_ Registrar.

Registrar.

Registrar.

AD

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED

1935

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

## PLACE OF DEATH

County of BannockCity of PocatelloRegistration District No. 28Primary Registration District No. 2161(No. Lynn Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME (Infant) Mena(a) Residence. No. 338 N. Third St.Length of residence in city or town where death occurred. 5 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds. (If nonresident give city or town and state)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE \_\_\_\_\_ 5. Single, Married, Widowed, or Divorced (write the word) \_\_\_\_\_5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of \_\_\_\_\_6. DATE OF BIRTH (month, day, and year) Jan 5 - 1935

7. AGE Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or min. \_\_\_\_\_

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_12. BIRTHPLACE (city or town) Pocatello  
(State or country) Idaho13. NAME Genaro Mena14. BIRTHPLACE (city or town) Mexico  
(State or country) \_\_\_\_\_15. MAIDEN NAME Carmen Gutierrez16. BIRTHPLACE (city or town) Mexico  
(State or country) \_\_\_\_\_17. INFORMANT Genaro Mena  
(Address) Pocatello Idaho18. (BURIAL) CREMATION, OR REMOVAL  
Place Pocatello Date Jan 7, 193519. UNDERTAKER Byron R. Raymond  
(Address) Pocatello Idaho20. FILED Jan 5, 1935 C. Ray  
Registrar

DO NOT WRITE IN THIS SPACE

State File No. S 92019Local Registrar's No. 283

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Jan 5, 193522. I HEREBY CERTIFY, That I attended deceased from 1-5-1935, to 1-5-1935, 1935.I last saw him alive on 1-5-1935, 1935; death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance

were as follows: \_\_\_\_\_ Date of onset \_\_\_\_\_

Still 13 amOther contributory causes of importance: mother pneumonia

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Lab Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? NO Date of injury \_\_\_\_\_, 1935.Where did injury occur? None

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public

place. NoneManner of injury NoneNature of injury None

24. Was disease or injury in any way related to occupation of deceased?

If so, specify Still 13 am(Signed) Still 13 am, M. D.(Address) Pocatello Idaho

# UNITED STATES STANDARD CERTIFICATE OF DEATH

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as *servant—private family*, *cook—hotel*, etc. For a person who had no occupation whatever write *none*.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry of business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employees," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner*, *weaver*, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill*, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer*, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as *carpenter, painter, machinist*, etc. Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

STATEMENT OF CAUSE OF DEATH.—Cause of death means the disease, injury, or complication which causes death, *not* the mode of dying, *e. g.*, heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

### EXAMPLE I

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

<i>Arteriosclerosis</i>	1915
<i>Chronic interstitial nephritis</i>	1921
<i>Cerebral hemorrhage</i>	July 5, 1927

Other CONTRIBUTORY CAUSES of importance:

*Gallstones* *May 1, 1923*

## EXAMPLE II

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other CONTRIBUTORY CAUSES of importance:

Gastroenteritis	1 year
-----------------	--------

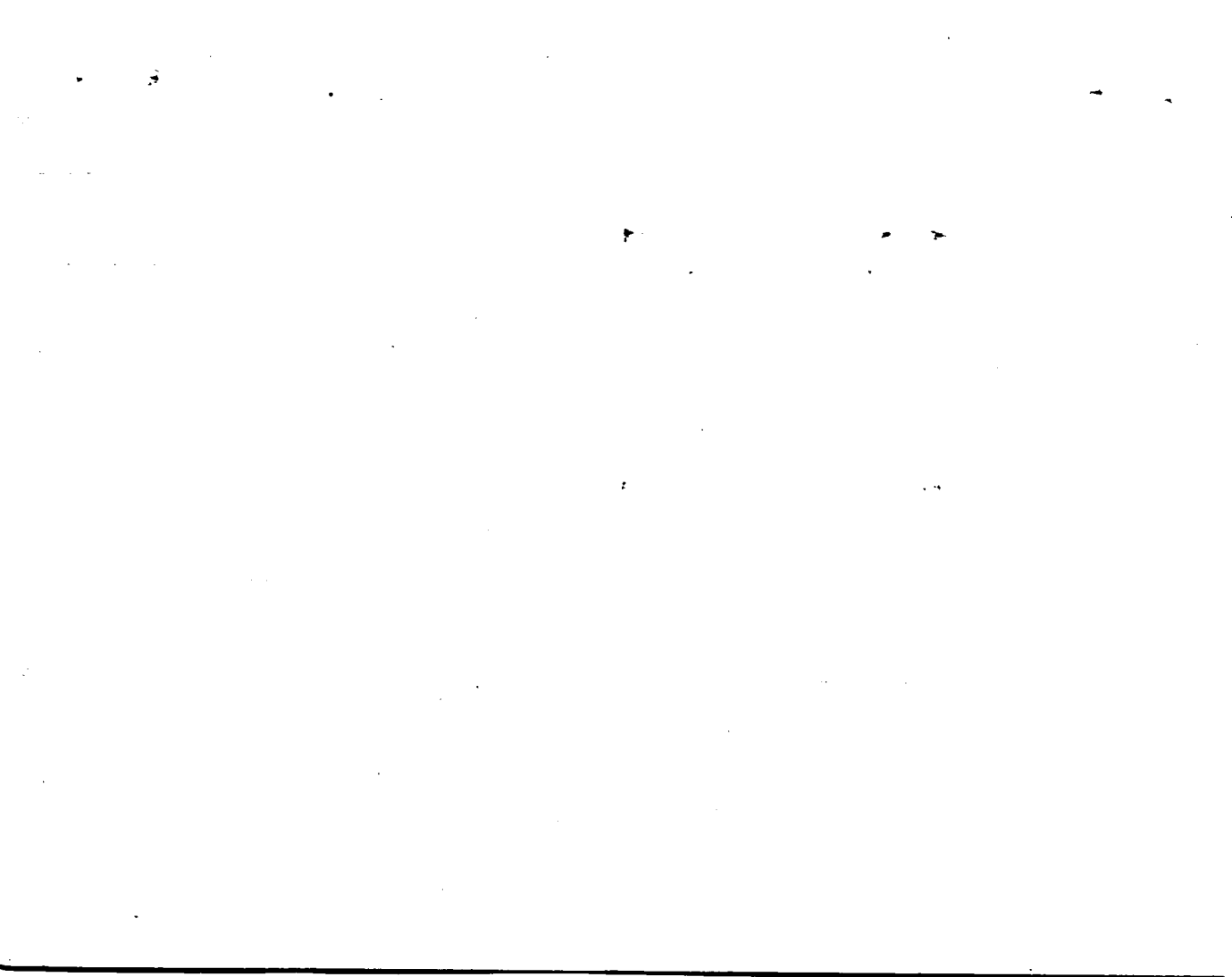
ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

10 17  
517



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

294-211004-249  
PLACE OF BIRTH Bear Lake RECEIVED AUG 10 1921 STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
County of Montpelier BUREAU OF VITAL STATISTICS  
City of Montpelier CERTIFICATE OF BIRTH 92041 S  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 52 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2136 Registered No. \_\_\_\_\_  
FULL NAME OF CHILD No name Still born  
(Certificate of no value without full name of child.)  
Sex of Child Girl Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legitimate? Yes Date of birth 7/11, 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)  
What bactericidal solution was used in eyes? Still Born  
Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 5  
FULL NAME FATHER Thomas Bruce FULL MAIDEN NAME MOTHER Erna Smith  
RESIDENCE Montpelier RESIDENCE Montpelier  
COLOR White AGE AT LAST BIRTHDAY 47 COLOR White AGE AT LAST BIRTHDAY 42  
(Years) (Years) (Years) (Years)  
BIRTHPLACE Ogden BIRTHPLACE Bernington  
OCCUPATION Farming OCCUPATION Housekeeping  
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*  
I hereby certify that I attended the birth of this child, who was Still born at 5-P. M.  
on the date above stated. (Born alive or stillborn)  
(Signature) Elmer E. Strickley  
Physician  
(Physician or midwife)  
Give names added from a supplemental report. \_\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_  
Address Montpelier, Ida  
Filed 7-1- 1921 Registrar. \_\_\_\_\_



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 34673

## 1. PLACE OF DEATH

County of

Registration District No. 52

Primary Registration District No. 2136

City of

(No.

AUG 10 1921

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

Male

White

Infant  
(Write the word.)

6. DATE OF BIRTH

July 11

in

1921  
(Month) (Day) (Year)

7. AGE

Still Born

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thos. Bruce

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Erna Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo. Bruce  
Georgetown, Ida

15.

Filed

8-1-21 by H. H. H. H.

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 11 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 11 1921 to July 11 1921  
that I last saw h. E. E. on July 11 1921  
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Elmer E. H. H.

7/12/21 (Address) Montpelier, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Montpelier, Ida

7-12-21

20. UNDERTAKER

ADDRESS

Geo. Bruce

Montpelier

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

249-231004-295

PLACE OF BIRTH

RECEIVED

AUG 10 1921

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

County of

City of

Registration District No.

File No.

No.

St.

Primary Registration District No.

Registered No.

FULL NAME OF CHILD

Sex of Child

Female

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti  
mate?

yes

Date of  
Birth

7 31

1921

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

FULL  
NAME

HARRY L. SMITH

FULL  
MAIDEN  
NAME

CLARA KIENZ

RESIDENCE

Montpelier

RESIDENCE

Montpelier

COLOR

white

AGE AT LAST  
BIRTHDAY

36

(Years)

COLOR

white

AGE AT LAST  
BIRTHDAY

28

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Idaho

OCCUPATION

R.R. Engineer

OCCUPATION

Housewife

Number of child of this mother, including present birth

7

Number of children of this mother now living, including present birth

4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Stillborn

at

11. 30 PM.

on the date above stated.

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

Registrar

Registrar

REPORT OF THE

1911

AUG 27 1921

BUREAU OF VITAL  
STATISTICS

Boise, Idaho, ..... 192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place { City ..... *Montpelier* .....  
 of { Street .....  
 Birth { County ..... *Bear Lake* .....

File Number ..... *92047* .....

Reg. on Dist. No. ....

Sex of Child. .... *female* .....Date of Birth *Aug 1* ..... 1921 .....

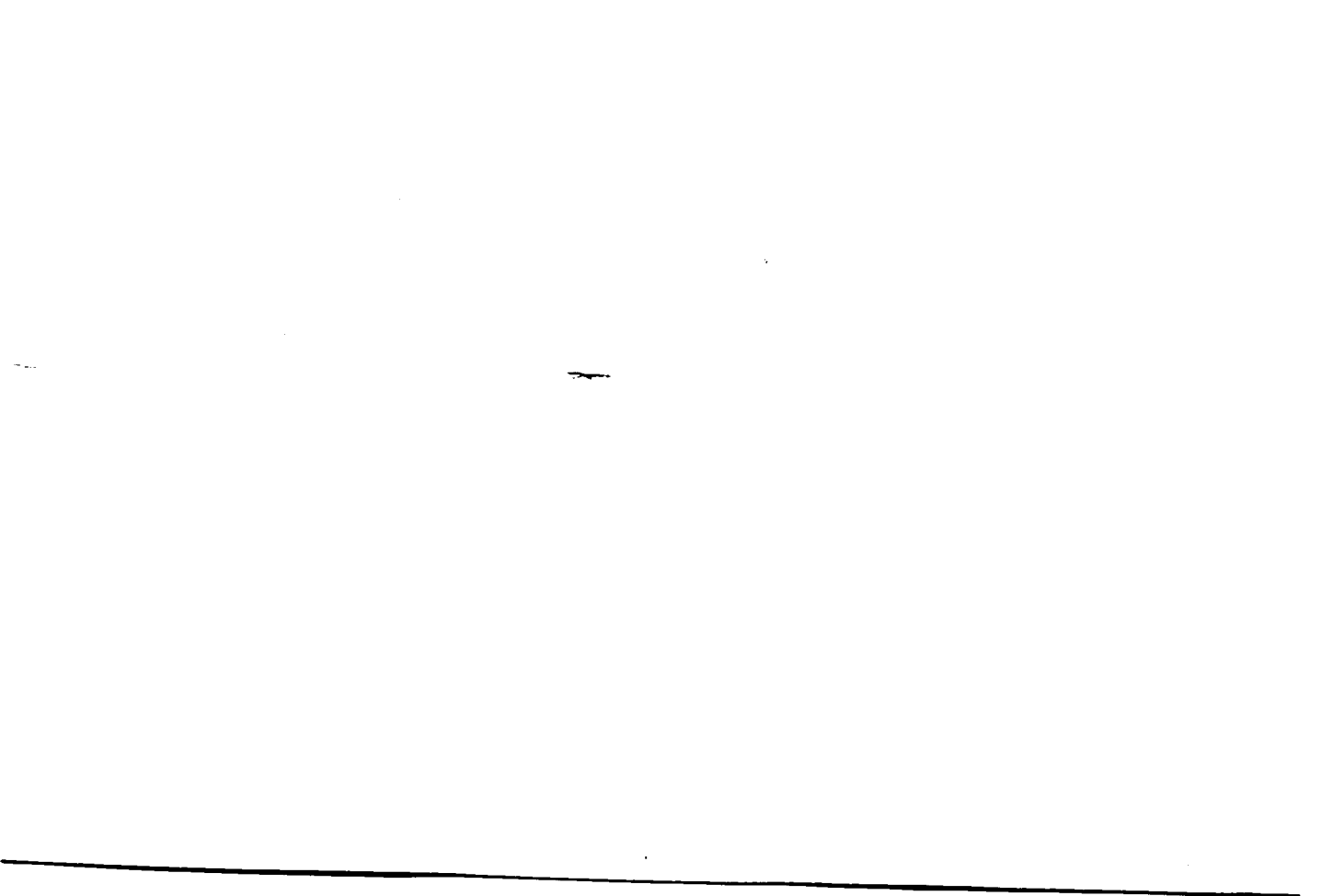
Father ..... *Harry L. Smith* .....  
 Full Name

Mother ..... *Clara Bienz* .....  
 Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

..... *Merie Smith* .....  
 Child's Name in Full

..... *Harry L. Smith* .....  
 Signature of Father or Mother





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Beauregard

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5

Primary Registration District 5

(No. ....)

**RECEIVED**  
**AUG 10 1921**  
**BUREAU OF VITAL STATISTICS**

St.)

State of Idaho  
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 34668

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby

Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Stillborn  
(Write the word.)

6. DATE OF BIRTH.

Aug  
(Month)

1  
(Day)

1921  
(Year)

7. AGE

Stillborn

IF LESS than 1 day  
how many .... hrs. or  
..... min.?"

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. L. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Clara Biam

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. L. Smith

(Address)

Montpelier, Idaho

15.

Filed

8-7-21

1921

W. H. H. H.

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Stillborn July 31  
(Month) (Day) (Year)

17.

I HEREBY CERTIFY, That I attended deceased from

..... 191..... to ..... 191.....

that I last saw h..... alive on ..... 191.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) ..... Yrs..... mos..... ds.

Contributory  
(Secondary)

(Duration) ..... Yrs..... mos..... ds.

(Signed)

J. P. Galetta M. D.

8-4-1921 (Address) Montpelier

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs..... mos..... days, State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Montpelier Idaho

DATE OF BURIAL

Aug 1 1921

20. UNDERTAKER

F. M. Williams

ADDRESS

Montpelier Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia, Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of .....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

463-218-006-699

PLACE OF BIRTH

County of Burley

City of Blackfoot

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

RECEIVED

Registration District No. 121

AUG 10 1921

BUREAU OF VITAL

Primary Registration District No. 1007

Elizabeth Dolan

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S 92070

File No. \_\_\_\_\_

Registered No. 249

Sex of Child Female Twin Triplet or other? \_\_\_\_\_ and \_\_\_\_\_ Number in order of birth \_\_\_\_\_ Legit mate? yes Date of Birth July 18 19 21 (Month) (Day) (Year)

FULL NAME FATHER Thos. L. Dolan

RESIDENCE Blackfoot, Idaho

COLOR White AGE AT LAST BIRTHDAY 34 (Years)

BIRTHPLACE mt

OCCUPATION Merchant

FULL MAIDEN NAME MOTHER Arlene Warden

RESIDENCE Blackfoot, Idaho

COLOR White AGE AT LAST BIRTHDAY 34 (Years)

BIRTHPLACE mas

OCCUPATION Housewife

Number of child of this mother, including present birth. 2 Number of children of this mother now living, including present birth. 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born at 10. 4. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. W. Mitchell, M.D.

(Physician or midwife)

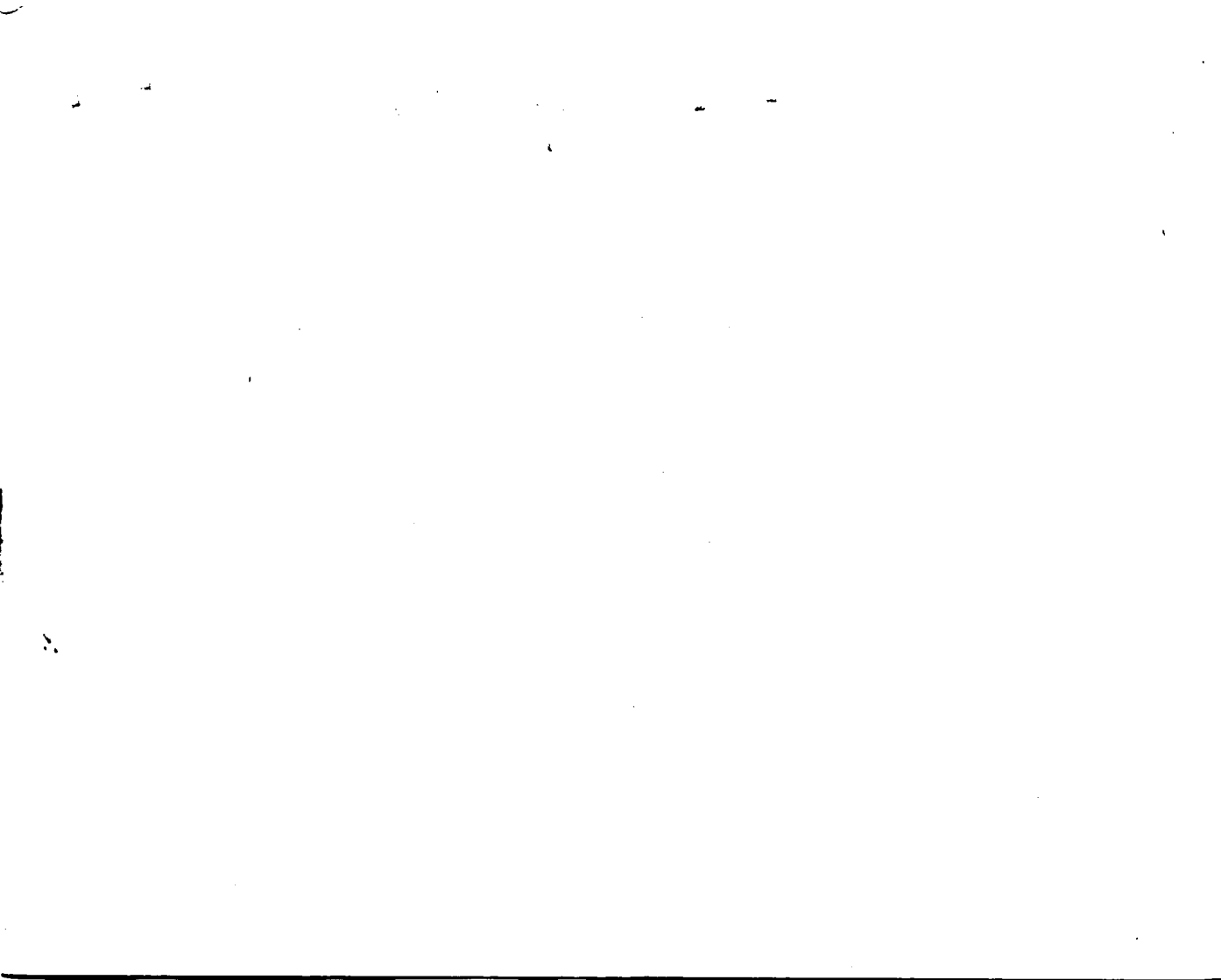
Given names added from a supplemental report.

Address Blackfoot, Idaho

Filed Aug 3 1921 Mr. Talbot

Registrar

Registrar



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. **34716**  
Registered No. **100**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

Registration District No. **121**County of **Blaine**Registration District No. **121**City of **Blackfoot**St. **Idaho**

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL

## 2. FUNERALS

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw **deceased** alive on **July 18** 19**21** and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Signed)

19**21**

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name or gin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

157-2

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

691-221-006-389

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of Bingham

RECEIVED

CERTIFICATE OF BIRTH

S

92157

City of Moreland

JUL 13 1921

BUREAU OF VITAL

Registration District No. 121

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2194 Registered No. 914

Hospital \_\_\_\_\_

FULL NAME OF CHILD

No name Clary

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> Number in order of birth <u>1</u>	Legiti mate? <u>yes</u>	Date of Birth <u>June 21 1921</u> (Month) (Day) (Year)
----------------------------	---	-------------------------	---

FATHER  
FULL NAME William P. Wray  
RESIDENCE Moreland  
COLOR White AGE AT LAST BIRTHDAY 26  
(Years)  
BIRTHPLACE Utah  
OCCUPATION Farming

MOTHER  
FULL MAIDEN NAME Elsie Myrtle Christensen  
RESIDENCE Moreland  
COLOR White AGE AT LAST BIRTHDAY 18  
(Years)  
BIRTHPLACE Massachusetts  
OCCUPATION Housewife

Number of child of this mother, including present birth. / Number of children of this mother now living, including present birth. 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 4:24 P.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. W. Beck

(Physician or Midwife)

Given names added from a supplemental report.

Address Blackfoot, Ida

Filed July 8 1921 Mrs. Halvor E. Labrie

Registrar

Registrar

THE 10th DISTRICT  
OF THE  
CITY OF NEW YORK

1892

1



1

2

3

4



**RECEIVED**  
**AUG 23 1927**  
**BUREAU OF VITAL**  
**STATISTICS**

**STATE OF IDAHO**  
**DEPARTMENT OF PUBLIC WELFARE**

Boise, Idaho, .....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

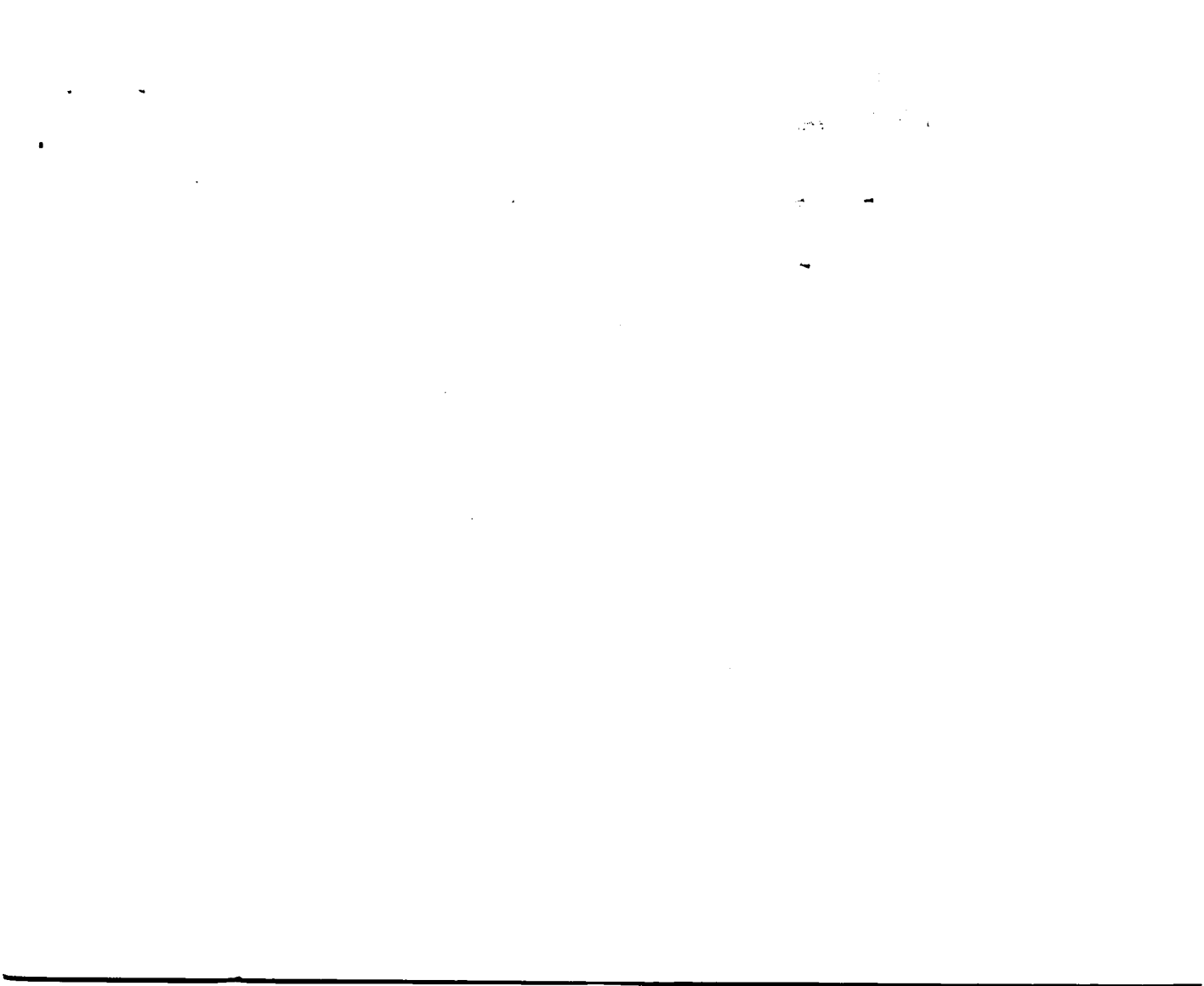
BUREAU OF VITAL STATISTICS.

Place of Birth	{	City <u>Worland</u> Street ..... County <u>Bingham</u>	File Number	<u>92157</u>
			Registration Dist. No.	.....
Sex of Child		<del>Female</del> <u>Male</u>	Date of Birth	<u>June 21</u> 192 <u>7</u>
Father		<u>William J. Gray</u> Full Name	Mother	<u>Elsie Myrtle Gray</u> Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Still Born. Was not named.  
 .....  
 Child's Name in Full

W. J. Gray  
 .....  
 Signature of Father or Mother



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## 1. PLACE OF DEATH.

County of Bingham  
City of Moreland

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

RECEIVED  
JUL 13 1921  
BUREAU OF VITAL STATISTICS

Registration District No. 21  
Primary Registration District No. 2191  
St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 34704  
Registered No. 76

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Single  
(Write the word.)

## 6. DATE OF BIRTH.

June 21 1921  
(Month) (Day) (Year)

## 7. AGE

Stillborn  
IF LESS than 1 day  
how many ..... hrs. or  
..... mos. ..... ds. .... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

William P. Wray

## 11. BIRTHPLACE OF FATHER

(State or Country) Utah

## 12. MAIDEN NAME OF MOTHER

Elsie Myrtle Christiansen

## 13. BIRTHPLACE OF MOTHER

(State or Country) Massachusetts

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William P. Wray

(Address) Moreland, Idaho

## 15.

Filed June 21 1921 Wm. H. Ellis, E. P. Patterson

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Stillborn June 21 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

June 21 1921, to June 21 1921,  
that I last saw him alive on Stillborn 1921,  
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

Stillborn 6 1/2 mo.  
(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... Yrs. .... mos. .... ds.

(Signed) W. A. Beck M. D.

June 21 1921 (Address) Blackfoot, Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Moreland, Idaho June 21 1921

## 20. UNDERTAKER

## ADDRESS

William P. Wray

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

189-6

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

PLACE OF BIRTH

863-1735011-249

County of Boundary

City of Lenia

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED  
CERTIFICATE OF BIRTH

AUG 13 1921

S 92212

Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_

Primary Registration District No. 1156

Registered No. \_\_\_\_\_

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>-</u> and { Number in order of birth <u>-</u>	Legitimate? <u>yes</u>	Date of birth <u>July 13 1921</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

What bacterioid solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FULL NAME <u>FATHER Harry Holmquist</u>	FULL MAIDEN NAME <u>MOTHER Bernice Smith</u>
RESIDENCE <u>Lenia, Ida.</u>	RESIDENCE <u>Lenia, Ida.</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>17</u> (Years)
BIRTHPLACE <u>Winn.</u>	BIRTHPLACE <u>Colo.</u>
OCCUPATION <u>Farmer.</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 4 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. E. Smy

(Physician or midwife)

Give names added from a supplemental report.

Address Bornes Ferry, Ida.

Filed 7/13 1921

Registrar.

Registrar.

[The following text is extremely faint and largely illegible. It appears to be a list or series of entries, possibly names and addresses, organized in columns. Some fragments are visible, such as "Mr. J. Edgar Hoover", "Washington, D.C.", and "New York, N.Y.", but the majority of the text cannot be transcribed accurately.]

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Boundary  
 City of Lenia

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79Primary Registration District No. 215-6

(RECEIVED) St.)

AUG 13 1921

## 2. FULL NAME

BONNER FERRY

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 34754

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

July 13<sup>th</sup> 1921  
 (Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
 how many hrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Idaho.

## 10. NAME OF FATHER

Harry Holmquist

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho.

## 12. MAIDEN NAME OF MOTHER

Bernice Smith

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Calo.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. E. Fry

(Address)

Bonner Ferry, Ida.

## 15.

Filed July 13-1921

E. E. Fry  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillborn  
(Premature - 7 mos.)

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

7/13 1921 (Address) Bonner Ferry, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Lenia, Ida

## DATE OF BURIAL

7/13 1921

## 20. UNDERTAKER

Harry Holmquist

## ADDRESS

Lenia, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

189-6



WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

419-2191-011-553  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Boundary  
City of Bonner Ferry

RECEIVED  
CERTIFICATE OF BIRTH

S 92215

No. 2156 Registration Date Aug 13 1921 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registrar Bureau of Vital Statistics Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u> } and { Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of birth <u>July 19 1921</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 1 ... Number of child of this mother now living, including present birth... 0 ...

FATHER	MOTHER
FULL NAME <u>Thos. Martin</u>	FULL MAIDEN NAME <u>Anna Nelson</u>
RESIDENCE <u>Bonner Ferry</u>	RESIDENCE <u>Bonner Ferry</u>
COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>29</u> (Years)	COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho</u>
OCCUPATION <u>linotype operator</u>	OCCUPATION <u>housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 4.30 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

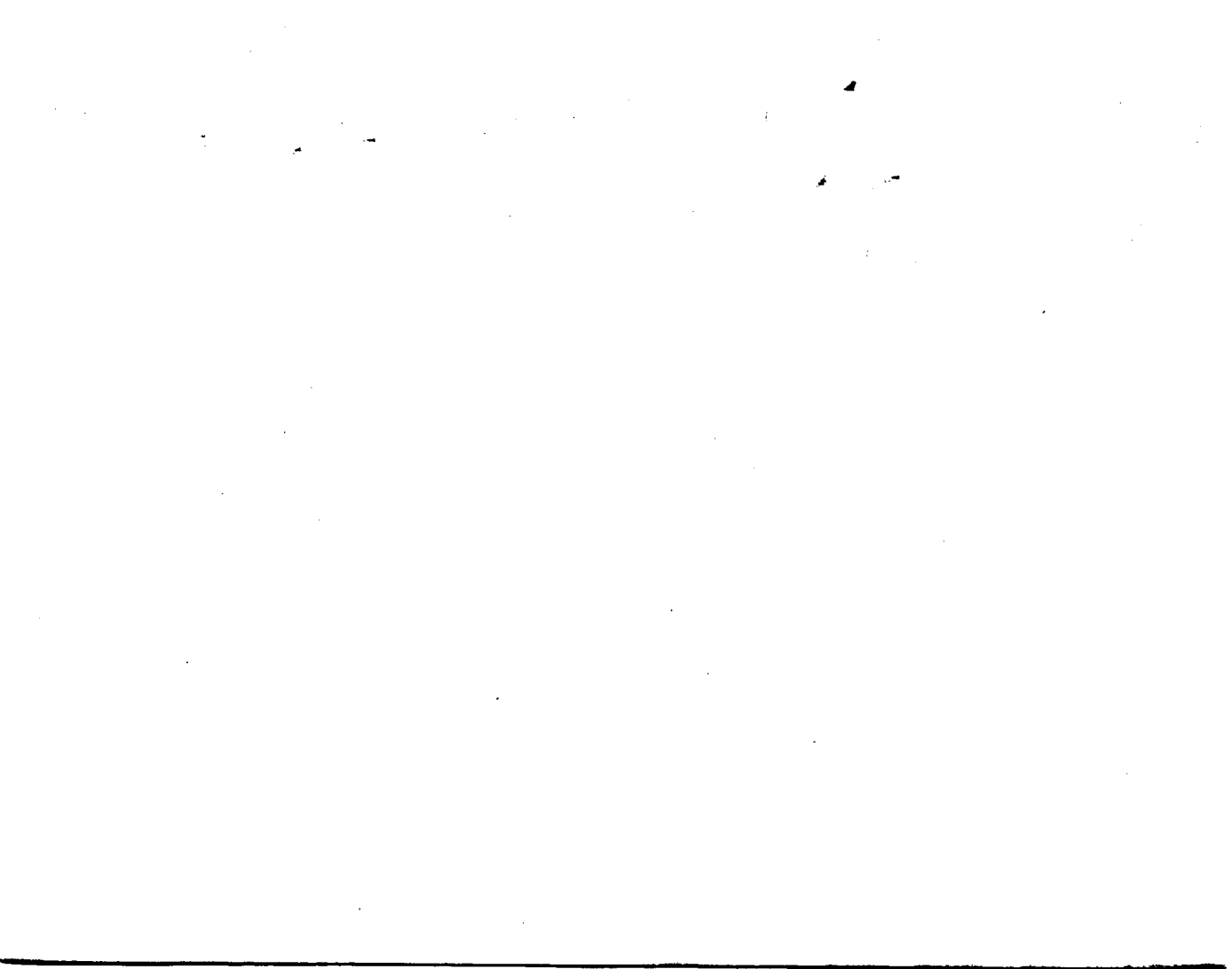
(Signature) E. E. Fry  
Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address Bonner Ferry, Ida.

Filed 7/19/1921 Registrar E. E. Fry

Registrar.



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of BoundaryCity of Bonner Ferry

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79Primary Registration District No. 2156

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 34755

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED

AUG 13 1921

## 2. FULL NAME

## PERSONAL AND STATISTICAL DATA

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

July 19th 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Thos. Martin

## 11. BIRTHPLACE OF FATHER

(State or Country)

Minn.

## 12. MAIDEN NAME OF MOTHER

Anna Nelson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Mich.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. E. Fry  
Bonner Ferry, Ida

## 15.

Filed

7/19/21 1921E. E. Fry  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

.....19..... to .....19.....

that I last saw h..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH\* was as follows:

Stillborn  
(Difficult labor)

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

7/19/21 (Address) Bonner Ferry, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Bonner Ferry, Ida 7/19/21

## 20. UNDERTAKER

## ADDRESS

O. R. Stookley Bonner Ferry

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*; who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

169-6

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

765-1291014335

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Canyon

JUL 14 1921

CERTIFICATE OF BIRTH

S 92238

City of Caldwell

BUREAU OF VITAL

STATISTICS

No. \_\_\_\_\_ St.

Registration District No. 3 File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2005 Registered No. 135

FULL NAME OF CHILD

Baby Pons.

Sex of  
Child

Male

Twins  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti  
mate?

Yes.

Date of  
Birth

June 29 1921  
(Month) (Day) (Year)

FULL  
NAME

FATHER

Charles R. Pons

FULL  
MAIDEN  
NAME

MOTHER

Edith J. Clemens

RESIDENCE

Caldwell - Idaho.

RESIDENCE

Caldwell - Idaho

COLOR

White

AGE AT LAST  
BIRTHDAY

23  
(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

19  
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Idaho.

OCCUPATION

Farming

OCCUPATION

Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

John H. Meyers, M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

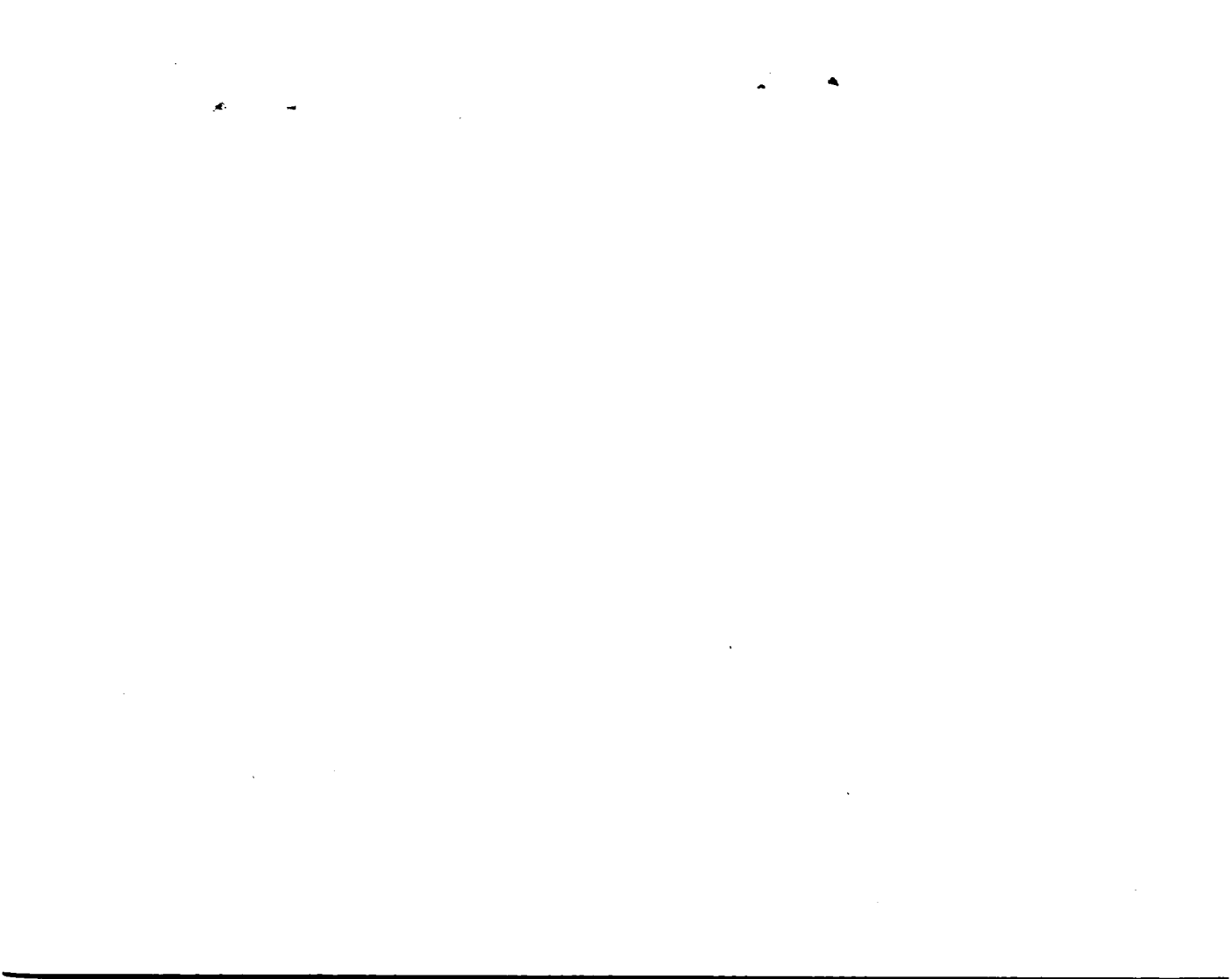
Caldwell - Idaho

Filed

June 29 - 1921 John H. Meyers

Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24		<div style="text-align: center;"> <b>RECEIVED</b>  <b>JUL 14 1921</b> </div>		<div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b>  <div style="float: right;">3</div> </div>		<div style="text-align: right;">             State of Idaho  <b>BOARD OF HEALTH</b>              Bureau of Vital Statistics              File No. <u>34793</u>              Registered No. <u>66</u> </div>	
1. PLACE OF DEATH		Registration District No. _____		County of <u>Canyon</u>		Primary Registration District No. <u>2005</u>	
City of <u>Caldwell</u>		STATISTICS		St.)			
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Baby Pons.</u>		If death occurred in a hospital, institution or camp give its NAME instead of street and number.			
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH.			
3. SEX <u>Male.</u>		4. COLOR OR RACE <u>White.</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Single</u> (Write the word.)		16. DATE OF DEATH <u>June 29 1921</u> (Month) (Day) (Year)	
6. DATE OF BIRTH <u>June 29 1921</u> (Month) (Day) (Year)		7. AGE <u>Still born.</u> yrs. mos. ds.		IF LESS than 1 day how many hrs. or min?		17. I HEREBY CERTIFY, That I attended deceased from <u>June 29 1921</u> , to <u>June 29 1921</u> , that I last saw him alive on <u>June 29 1921</u> and that death occurred on the date stated above, at <u>1:30 P. M.</u> The CAUSE OF DEATH* was as follows: <u>Still born - Premature birth.</u>	
8. OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business or establishment in which employed (or employer)		9. BIRTHPLACE <u>Idaho.</u> (State or Country)		10. NAME OF FATHER <u>Charles A. Pons.</u>		11. BIRTHPLACE OF FATHER <u>Utah.</u> (State or Country)	
12. MAIDEN NAME OF MOTHER <u>Edith J. Clemens.</u>		13. BIRTHPLACE OF MOTHER <u>Idaho.</u> (State or Country)		14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Chas. Pons</u> (Address) <u>Caldwell Idaho.</u>		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____	
15. Filed <u>June 30 1921</u> <u>John V. Meyer</u> Local Registrar		19. PLACE OF BURIAL OR REMOVAL <u>any on hill.</u>		DATE OF BURIAL <u>6-30 1921</u>		20. UNDERTAKER <u>V. Beckham Caldwell</u> ADDRESS _____	

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

189-6



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

994-006-014-119

PLACE OF BIRTH

RECEIVED  
JUL 14 1921

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C--25m-7-21-19

S 92242

County of Canyon

City of Middleton

BUREAU OF VITAL

Registration District No.

3

File No.

No. St.

Primary Registration District No.

2005

Registered No.

139

Hospital

FULL NAME OF CHILD

Sex of Child	.....	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate?	Yes	Date of Birth	July 6,	19 21
							(Month)	(Day)	(Year)

FULL NAME	FATHER
	Oscar Harry Zimmerman
RESIDENCE	
	Middleton, Idaho
COLOR	AGE AT LAST BIRTHDAY
White	32 (Years)
BIRTHPLACE	
	Idash.
OCCUPATION	
	Carpenter

FULL MAIDEN NAME	MOTHER
	Arellia Jarvis
RESIDENCE	
	Middleton, Idaho
COLOR	AGE AT LAST BIRTHDAY
White	27 (Years)
BIRTHPLACE	
	Idash.
OCCUPATION	
	Housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 8:30 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. C. Kaley

M. D.  
(Physician or midwife)

Given names added from a supplemental report.

19

Address Caldwell, Idaho

Filed July 7- 1921

Registrar

John H. Inayes -  
Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

415-225-048-819 Country  
PLACE OF BIRTH

County of Canyon

City of Nampa

No. R.B. 45 St.

Hospital —

Full Name of Child Shulant Marvity

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11—25m-4-15-18

RECEIVED CERTIFICATE OF BIRTH

AUG 10 1921

S92251

Registration District No. —  
BUREAU OF VITAL STATISTICS

File No. —

Primary Registration District No. 2000

Registered No. —

SEX OF CHILD <u>girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	<u>+</u>	and	Number in order of birth <u>+</u>	Legit- mate? <u>yes</u>	DATE OF BIRTH <u>July 25 1921</u> (Month) (Day) (Year)
FATHER			MOTHER			
FULL NAME <u>D.E. Marvity</u>			FULL MAIDEN NAME <u>Eliza Hartwell</u>			
RESIDENCE <u>Nampa Ida</u>			RESIDENCE <u>Nampa Ida</u>			
COLOR <u>white</u>			COLOR <u>white</u>			
AGE AT LAST BIRTHDAY <u>42</u> (Years)			AGE AT LAST BIRTHDAY <u>38</u> (Years)			
BIRTHPLACE <u>Ida</u>			BIRTHPLACE <u>Ida</u>			
OCCUPATION <u>Farmer</u>			OCCUPATION <u>Housewife</u>			

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born dead, at H.P. M  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J.H. Murray  
M.D.  
(Physician or midwife)

Given names added from a supplemental report.

Address Nampa Ida  
Filed Aug. 10 1921 Pearle Dodds  
Registrar Registrar

Indicate with check mark whether or not the child is a resident of the State of Indiana. If the child is a resident of the State of Indiana, check the box in the column headed "Resident of Indiana". If the child is not a resident of the State of Indiana, check the box in the column headed "Not a Resident of Indiana".

**Full Name of Child**

County of \_\_\_\_\_  
 State of \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Sex of Child \_\_\_\_\_  
 Color \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Occupation \_\_\_\_\_

**FATHER**

Full Name \_\_\_\_\_  
 Residence \_\_\_\_\_  
 Color \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Age at Last Birthday \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Sex of Child \_\_\_\_\_  
 Color \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Occupation \_\_\_\_\_

**MOTHER**

Full Name \_\_\_\_\_  
 Residence \_\_\_\_\_  
 Color \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Age at Last Birthday \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Sex of Child \_\_\_\_\_  
 Color \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Occupation \_\_\_\_\_

**CERTIFICATE OF ATTENDANCE AND SIGNATURE OF PHYSICIAN**

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
 (Name of child)  
 on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.  
 (Date of birth)  
 I have made an attending physician in \_\_\_\_\_  
 and have the latter, immediately after  
 the birth of this child, signed a certificate  
 of birth, which I have attached to this  
 certificate of attendance and which shall be  
 given to the parents of the child.  
 Given names which have been registered: \_\_\_\_\_  
 (List of names)  
 Address \_\_\_\_\_  
 (Address of physician)  
 Signature of physician \_\_\_\_\_  
 (Signature of physician)  
 Registered \_\_\_\_\_  
 (Registered name of physician)

25521

STATE OF IDAHO  
 BUREAU OF VITAL STATISTICS  
 Form No. 11-1-1917

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Canyon  
City of MarbletonRegistration District No. 7  
Primary Registration District No. 1006  
(No. 1006 St.)If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

## 2. FULL NAME

BUREAU OF VITAL  
STATISTICSInfant MarvetyFile No. 34777  
Registered No. 34777If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

July 25 1921  
(Month) (Day) (Year)

## 7. AGE

Still born  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work  
(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)Infant

## 9. BIRTHPLACE

(State or Country)

Canyon Co. Idaho10. NAME OF  
FATHERD. E. Marvety11. BIRTHPLACE  
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME  
OF MOTHEREliza Hartwell13. BIRTHPLACE  
OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. E. Marvety

(Address)

Marbleton Idaho

## 15.

Filed July 24 1921 Pearl Dodds  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

July 25 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

July 25 1921, to — 19  
that I last saw h. alive on — 19and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Murray M. D.7/26 1921(Address) Marbleton Idaho\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted  
if not at place of death?Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Volunteer Lawman7/24 1921

## 20. UNDERTAKER

## ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1896

253-112101K-165  
PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
RECEIVED

AUG 10 1921

CERTIFICATE OF BIRTH

BUREAU OF VITAL STATISTICS

S 92256

County of Canyon

City of Nampa

No. 178 - 3 St.

Registration District 7

File No.

Primary Registration District No. 2006

Registered No.

Hospital  
FULL NAME OF CHILD Unnamed, Betts

Sex of Child M Twin Triplet or other? and Number in order of birth (To be answered only in event of plural births) Legitimate? yes Date of Birth 7-12 1921 (Month) (Day) (Year)

FATHER  
FULL NAME Archie L. Betts  
RESIDENCE R.D. 3 Nampa  
COLOR White AGE AT LAST BIRTHDAY 25 (Years)  
BIRTHPLACE Kansas  
OCCUPATION Rancher

MOTHER  
FULL MAIDEN NAME Minnie Grace Jones  
RESIDENCE R.D. 3 Nampa  
COLOR White AGE AT LAST BIRTHDAY 27 (Years)  
BIRTHPLACE Missouri  
OCCUPATION Ranchers Wife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ~~born~~ Stillborn on the date above stated. (Born alive or stillborn) at 5:30 P. M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) O.R. Meredith D.O.

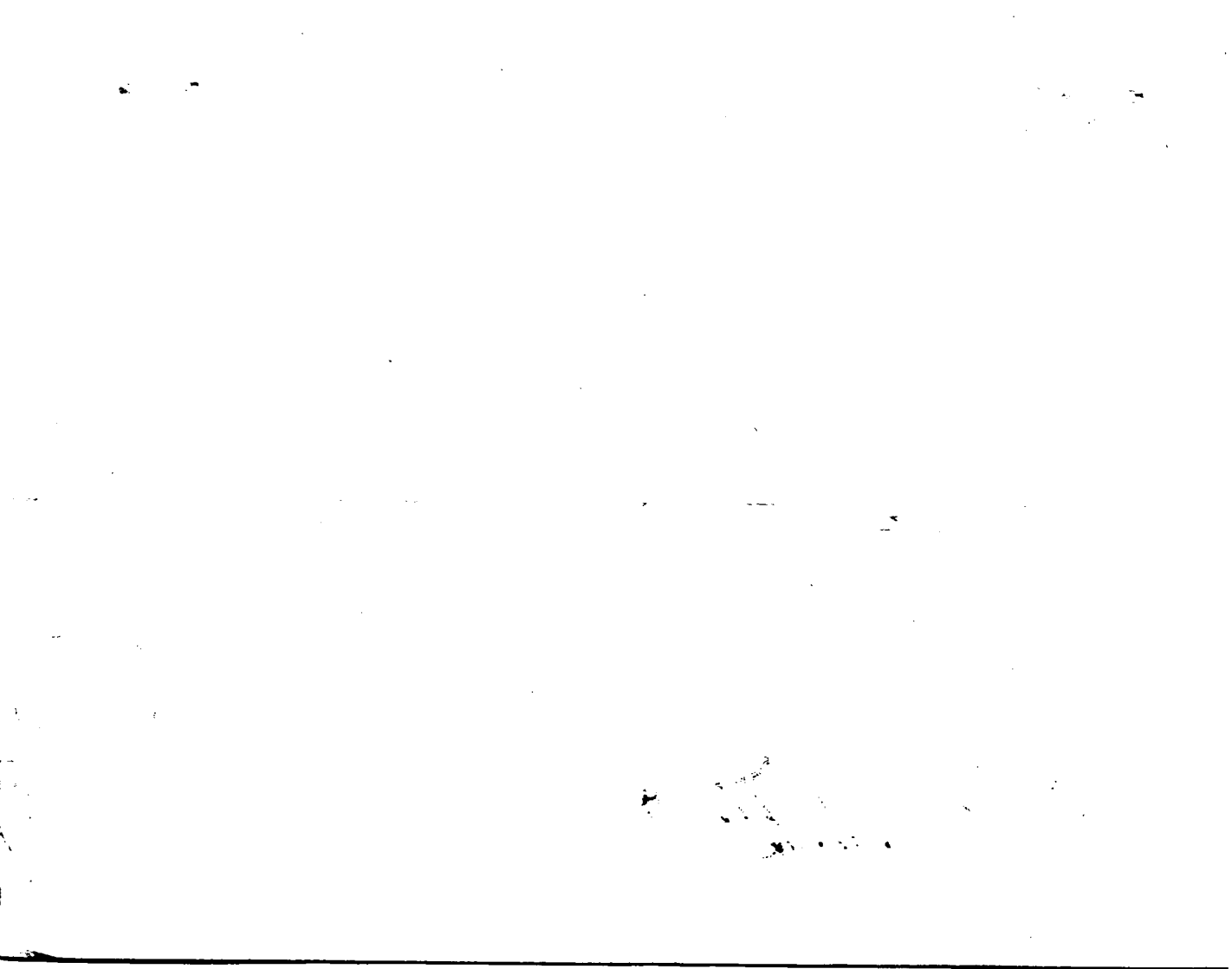
(Physician or midwife)

Given names added from a supplemental report.

Address  
Aug 10 1921 Pearl Dodd  
Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.





MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

# CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 34768

1. PLACE OF DEATH.

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 7

Primary Registration District No. 2006

(No.

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7 - 12 - 1921  
(Month) (Day) (Year)

7. AGE

..... yrs. .... mos. .... ds.

IF LESS than 1 day  
how many .... hrs. or  
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Archie L. Betts

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Minnie Grace Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

D. R. Meredith Sr.  
Nampa

15.

Filed

Aug. 18 1921 Pearl Dodd

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Previous to 7-12-1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from at Birth to July 12 1921 that I last saw him alive on 1921

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Heart attack of Card about 1/2 inch (Duration) 1/2 hr. 1/2 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) D. R. Meredith Sr.

7/17/1921 (Address) Nampa

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. .... yrs. .... mos. .... days. In the State. .... yrs. .... mos. .... days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Disposed of on the 7-12-1921

20. UNDERTAKER

ADDRESS

farm

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

152-2

544-118,014-544  
PLACE OF BIRTH

County of Carson

City of Brownmont - rural

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Full Name of Child \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 2006

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

RECEIVED

AUG 10 1921

CERTIFICATE OF BIRTH

S

92262

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Emmert

SEX OF CHILD <u>Boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	Number in order of birth	Legiti- mate?	DATE OF BIRTH <u>July 18</u> 19 <u>21</u> (Month) (Day) (Year)
FULL NAME <u>L. H. Hake</u>	FATHER		FULL MAIDEN NAME <u>R. L. Emmert</u>	MOTHER
RESIDENCE <u>Brownmont Ida</u>	RESIDENCE		<u>Brownmont Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>22</u> (Years)	
BIRTHPLACE <u>Mo</u>	BIRTHPLACE <u>Tenn.</u>			
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>			

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

\_\_\_\_\_ 19 \_\_\_\_\_

(Born alive or stillborn) \_\_\_\_\_, at 11:50 A. M

(Signature) J. H. Murray  
M.D.  
(Physician or midwife)

Address ampa Idaho

Filed Aug. 10, 1921 Pearle Dodds  
Registrar

PLACE OF BIRTH

County of

No.

Year of birth

Full Name of Child

SEX  
CHILD

FULL  
NAME

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

FATHER

Twins  
Triplet  
or other

Number  
and  
order  
of birth

Local  
date

DATE OF  
BIRTH

MOTHER

FULL  
MAIDEN  
NAME

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

AGE AT LAST  
BIRTHDAY

AGE AT LAST  
BIRTHDAY

Number of child of this mother, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Number of children of this mother now living, including present birth

I hereby certify that I attended the birth of this child, who was

If there were any other children born to this mother, their names and birth dates should be stated in this report.

(Given names added from a supplemental report.)

Address

Filed

Registered

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

File No.

Registered No.

AR

635-102-014-453  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
**RECEIVED** DEPARTMENT OF PUBLIC WELFARE  
 BUREAU OF VITAL STATISTICS  
**AUG 13 1921**  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF BIRTH

County of Canyon

City of \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Registration District No. 3 File No. 92307Primary Registration District No. 2005 Registered No. 743

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>M.</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>July 2</u> 19 <u>21</u> (Month) (Day) (Year)
------------------------	---	-----------	--------------------------------	------------------------	--

FULL NAME <u>John F. Helech</u>	FATHER
---------------------------------	--------

RESIDENCE <u>R 7 D. 1. Caldwell</u>	
-------------------------------------	--

COLOR <u>CO.</u>	AGE AT LAST BIRTHDAY <u>46</u> (Years)
------------------	---

BIRTHPLACE <u>Texas.</u>	
--------------------------	--

OCCUPATION <u>Farmer</u>	
--------------------------	--

FULL MAIDEN NAME <u>Ethel Debus</u>	MOTHER
-------------------------------------	--------

RESIDENCE <u>R 7 D. 1. Caldwell</u>	
-------------------------------------	--

COLOR <u>CO.</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
------------------	---

BIRTHPLACE <u>Wash.</u>	
-------------------------	--

OCCUPATION <u>Wife</u>	
------------------------	--

Number of child of this mother, including present birth <u>1</u>	Number of children of this mother now living, including present birth <u>1</u>
--	--

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report. \_\_\_\_\_

19. \_\_\_\_\_

Address \_\_\_\_\_

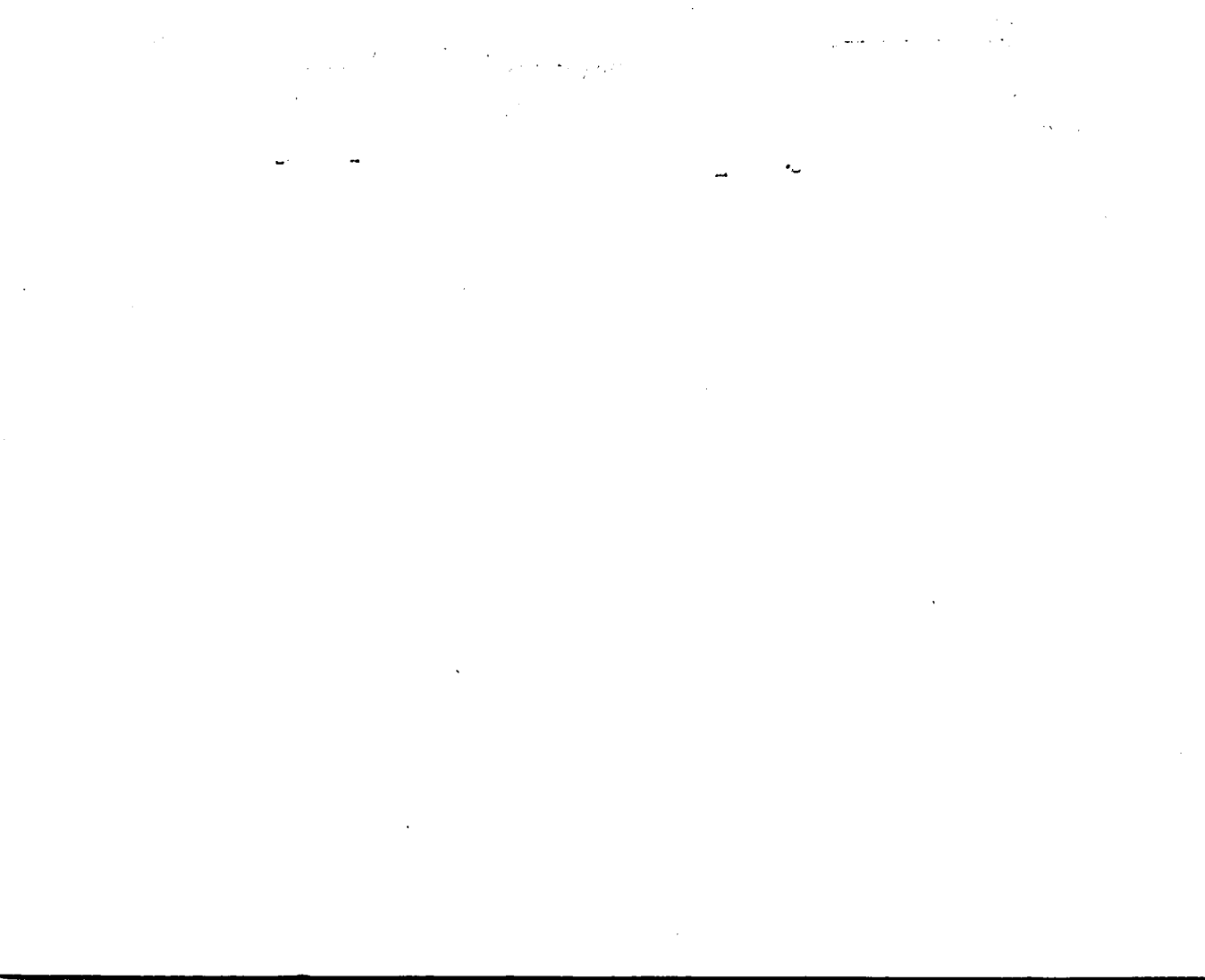
Filed \_\_\_\_\_

Registrar. \_\_\_\_\_

(Physician or midwife)

IdahoJuly 12 1921 John V. Meyer

Registrar.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **32830**  
Registered No. **12**

## 1. PLACE OF DEATH

Registration District No. **3**  
County of **Ada** Primary Registration District No. **2005**  
City of **Star** St.

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Infant Fletcher**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **m.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**

## 6. DATE OF BIRTH

**Feb 2** 19**21**  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many ..... hrs.  
or ..... min. ?  
Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

**none**

## 9. BIRTHPLACE

(State or Country)

**Idaho.**

## 10. NAME OF FATHER

**John F Fletcher**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Texas**

## 12. MAIDEN NAME OF MOTHER

**Ethel Dykes**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**unknown**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs Adeau L. Nelson**

(Address)

## 15.

Filled **Feb. 3 - 1921** **John L. Meyer**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Feb 2** 19**21**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from **Feb 2** 19**21** to **Feb 2** 19**21**

that I last saw him alive on **Feb 2** 19**21**

and that death occurred on the date stated above, at **Star** M.

The CAUSE OF DEATH\* was as follows:

**Still Born.**

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

**W. H. Hall** M. D.  
**Star Idaho**  
19**21** (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

**Morris Hill Cemetery**

## DATE OF BURIAL

**Feb 3** 19**21**

## 20. UNDERTAKER

**Susmers & Scheel**

## ADDRESS

**Boise Idaho**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



BIRTH

215-711  
013 593

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

S 92343

County BlaineCity of CoralNo. 1 mile West1 " South

Hospital \_\_\_\_\_

RECEIVED

AUG 10 1921

BUREAU OF VITAL

STATISTICS

Registration District No. 58<sup>th</sup>

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

FULL NAME OF CHILD Jimmie SanfordSex of Child maleTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate?yesDate of  
BirthJuly 11<sup>th</sup> 1921  
(Month) (Day) (Year)FULL  
NAME

FATHER

Thomas Leroy Sanford

RESIDENCE

Coral, Idaho

COLOR

whiteAGE AT LAST  
BIRTHDAY27  
(Years)

BIRTHPLACE

New York

OCCUPATION

FarmerFULL  
MAIDEN  
NAME

MOTHER

Mrs Fay Nicholson

RESIDENCE

Coral, Idaho

COLOR

whiteAGE AT LAST  
BIRTHDAY74  
(Years)

BIRTHPLACE

Missouri

OCCUPATION

HousewifeNumber of child of this mother, including present birth 1<sup>st</sup>Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.Still-born, at 12<sup>30</sup> P. M.  
(Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

L Wellencheck  
Phys.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Fairfield Idaho

Filed

July 28<sup>th</sup> 1921L Wellencheck

Registrar

Registrar

STATE OF ILL.  
BUREAU OF CHARTERS  
CERTIFICATE OF THE

WITH

COUNTY

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of CamasCity of Conel

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58<sup>d</sup>Primary Registration District No. 2138

BUREAU OF VITAL STATISTICS

## 2. FULL NAME

Jimmie SanfordState of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 34765

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white single  
(Write the word.)

## 6. DATE OF BIRTH

July 11<sup>d</sup> 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Camas Co. Idaho

## 10. NAME OF FATHER

Thomas Leroy Sanford

## 11. BIRTHPLACE OF FATHER

(State or Country)

New York

## 12. MAIDEN NAME OF MOTHER

Mrs Fay Nicholson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Neva Sanford (per L.W.)(Address) Conel, Idaho

## 15.

Filed

Aug 7<sup>th</sup> 1921LWlencheck  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

July 11<sup>d</sup> 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

July 11<sup>d</sup> 1921 to July 11<sup>d</sup> 1921  
that I last saw him (Born dead) 19  
and that death occurred on the date stated above, at 12<sup>20</sup> P.M.

The CAUSE OF DEATH\* was as follows:

Prolonged cranial pressure - also  
pressure on medulla

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

LWlencheck

M. D.

Aug 7<sup>th</sup> 1921

(Address)

Fairfield, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

19

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1529

334-2231013-693

Form V. S. No. 11-C--25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 92346

County of CamasCity of ManardRegistration District No. 58<sup>d</sup>

File No. \_\_\_\_\_

No. \_\_\_\_\_ St.

Primary Registration District No. 2138 Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Sarah Gale blutten

Sex of Child <u>Female</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and	Number in order of birth _____	Legiti mate? <u>yes</u>	Date of Birth <u>July 23<sup>d</sup> 1921</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	-------------------------	---

FULL NAME <u>Edmen Samuel blutten</u>	FATHER
RESIDENCE <u>Manard, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Pennsylvania</u>	
OCCUPATION <u>Rancher</u>	

FULL MAIDEN NAME <u>Luella Willock</u>	MOTHER
RESIDENCE <u>Manard, Idaho</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Pennsylvania</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 1<sup>st</sup> Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Still - born at 2<sup>30</sup> A. M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

I W. L. L. check  
Phys.  
(Physician or midwife)

Given names added from a supplemental report.

Address

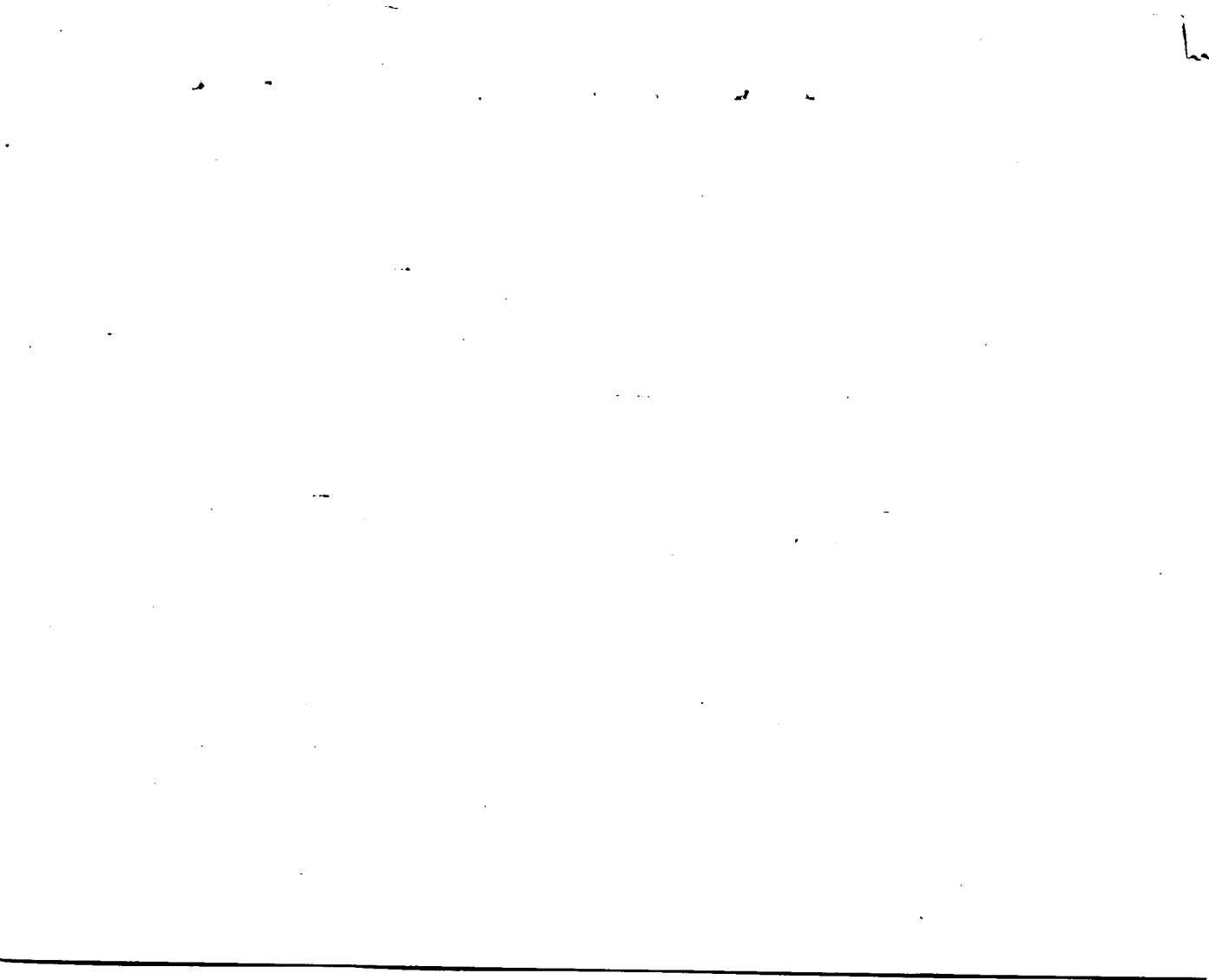
Fairfield, Idaho

Filed

Aug 6<sup>th</sup> 1921

Registrar

Registrar



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Camas  
City of ManardRECEIVED  
AUG 10 1921Registration District No. 58<sup>d</sup>Registration District No. 2138File No. 34766

Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

BUREAU OF  
STATISTICSSarah Gale Blutter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

white

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

July 23<sup>d</sup> 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Camas Co. Idaho

## 10. NAME OF FATHER

Elmer Samuel Blutter

## 11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

## 12. MAIDEN NAME OF MOTHER

Luella Willock

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. E. S. Blutter (per L.W.)

(Address)

Manard, Idaho

## 15.

Filed

Aug 7<sup>th</sup> 1921L. W. Blencheck

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

July 23<sup>d</sup> 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

July 23<sup>d</sup> 1921, to July 23<sup>d</sup> 1921that I last saw h. (Still-born) 19and that death occurred on the date stated above, at 23<sup>00</sup> (M.)

The CAUSE OF DEATH\* was as follows:

Premature Birth  
(6 months gestation)

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. W. Blencheck

M. D.

Aug 7<sup>th</sup> 1921 (Address) Fairfield, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

19

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Græmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



954-119-022-954

PLACE OF BIRTH

RECEIVED  
AUG 3 1921

STATE OF IDAHO

Form V. S. No. 11-C-2m-1-1-18

County of Fremont

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 92315

City of AshtonRegistration District No. 102File No. 1

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 6Registered No. 77

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Betty Truman

Sex of Child

MaleTwin  
Triplet  
or other?

{

Number  
in order  
of birth

{

Legiti-  
mate?yesDate of  
Birth7-17-1921FULL  
NAMEJames S. Truman

FATHER

FULL  
MAIDEN  
NAMEGrace Truman

MOTHER

RESIDENCE

St. Anthony

RESIDENCE

St. Anthony, Ida.

COLOR

WhiteAGE AT LAST  
BIRTHDAY27 yrs.

COLOR

whiteAGE AT LAST  
BIRTHDAY27

BIRTHPLACE

Minnesota

BIRTHPLACE

Kentucky

OCCUPATION

Laborer

OCCUPATION

Housewife

Number of child of this mother, including present birth

3

Number of children of this mother now living, including present birth

2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was

Born alive

(Born alive or stillborn)

at 4:30 A.M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

C. C. [Signature]

(Physician or midwife)

STATE OF NEW YORK

IN SENATE

1871



**BUREAU OF VITAL  
STATISTICS**

Boise, Idaho,.....

*Aug 22*.....192*.1*

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

**BUREAU OF VITAL STATISTICS.**

Place of Birth { City *Marysville*  
Street .....  
County *Fremont*

File Number *92415*

Registration Dist. No. ....

Date of Birth *July 19*.....192*.1*

Sex of Child *male*.....

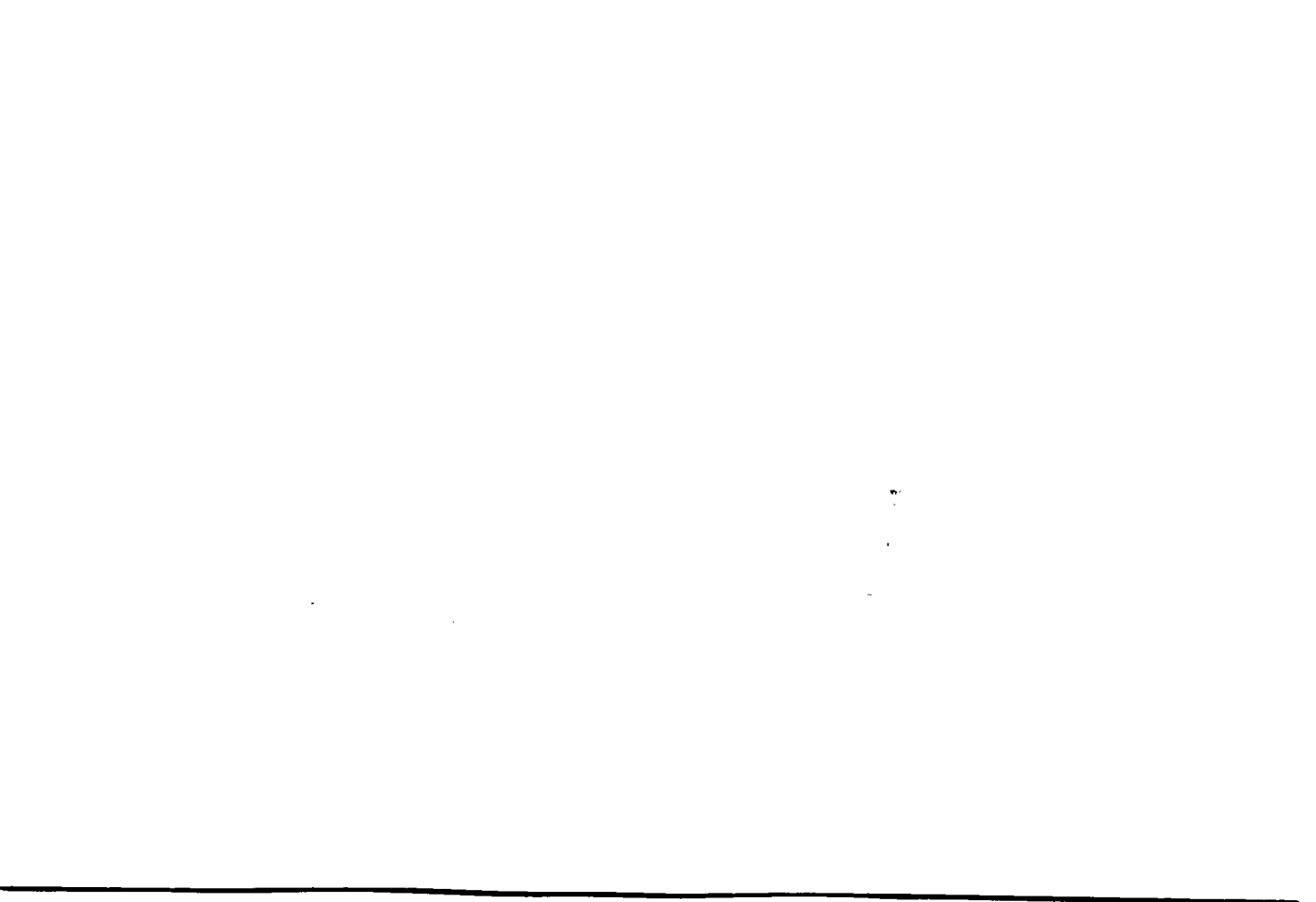
Father *James Smith Irman*  
Full Name

Mother *Grace Blevens*  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*No Name Given - Child born dead.*  
.....  
Child's Name in Full

*Grace Blevens Irman*  
.....  
Signature of Father or Mother



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

34836 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH  
County of Fremont Registration District No. 102  
City of Marysville Primary Registration District No. 6  
If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
AUG 3 1921

BUREAU OF VITAL STATISTICS

File No. 7  
Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Duman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED  
(Write the word.)

6. DATE OF BIRTH  
7 19 1921  
(Month) (Day) (Year)

7. AGE  
Yrs. Mos. ds.  
IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE  
(State or Country) Marysville Idaho

10. NAME OF FATHER  
James S Duman

11. BIRTHPLACE OF FATHER  
(State or Country) Minnesota

12. MAIDEN NAME OF MOTHER  
Grace Blevins

13. BIRTHPLACE OF MOTHER  
(State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Jesse B Duman  
(Address) Marysville Idaho

15. Filed 7-19 1921  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH  
7 19 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-19-1921 to 7-19-1921  
that I last saw h. alive on 7-19-1921  
and that death occurred on the date stated above, at 7-19-1921 M.  
The CAUSE OF DEATH\* was as follows:

Gravel  
(Duration) Yrs. mos. ds.  
Contributory (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) Wm. W. Wagoner M. D.  
7-19-1921 (Address) Wm. W. Wagoner

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death yrs. mos. days. In the State yrs. mos. days.  
Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Ryding Idaho DATE OF BURIAL 7-19-1921

20. UNDERTAKER Lincoln ADDRESS Ashton Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

855-111-024-355

PLACE OF BIRTH

County of Gooding

City of Bliss

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Registration District No. 24

Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

**S** 92433

Sex of Child <u>boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>June 11</u> (Month) (Day) (Year) <u>1921</u>
-------------------------	---	-----	--------------------------------	----------------------------	---

FULL NAME <u>A. H. Henderson</u>	FATHER
RESIDENCE <u>Bliss, Ida.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Wyoming</u>	
OCCUPATION <u>Assistant water master</u>	

FULL MAIDEN NAME <u>Alta Van Lusen</u>	MOTHER
RESIDENCE <u>Bliss, Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>housewife</u>	

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 8:40 A.M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. W. C. Lamb  
M. Bailey

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Gooding Idaho

Filed

8-3- 1921

J. F. Campbell

Registrar

Registrar





MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

236-106-029-369

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 92488

County of Salah

City of Poclaach. K.D.

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Registration District No. \_\_\_\_\_

BUREAU OF VITAL

STATISTICS

Primary Registration District No. 2145

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

FULL NAME OF CHILD not named - (Infant of F. H. Blood.)

Sex of Child <u>male</u>	<u>Male</u> or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>Aug 6 1921</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------	-------------------------	---

FATHER  
FULL NAME Fred. H. Blood  
RESIDENCE Salah Co  
COLOR White  
AGE AT LAST BIRTHDAY 43 (Years)  
BIRTHPLACE Cal.  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Anna H. Sweetmeyer  
RESIDENCE Salah Co  
COLOR White  
AGE AT LAST BIRTHDAY 38 (Years)  
BIRTHPLACE Ill.  
OCCUPATION House wife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born, at 10 P. M.  
on the date above stated. (Born alive or stillborn)

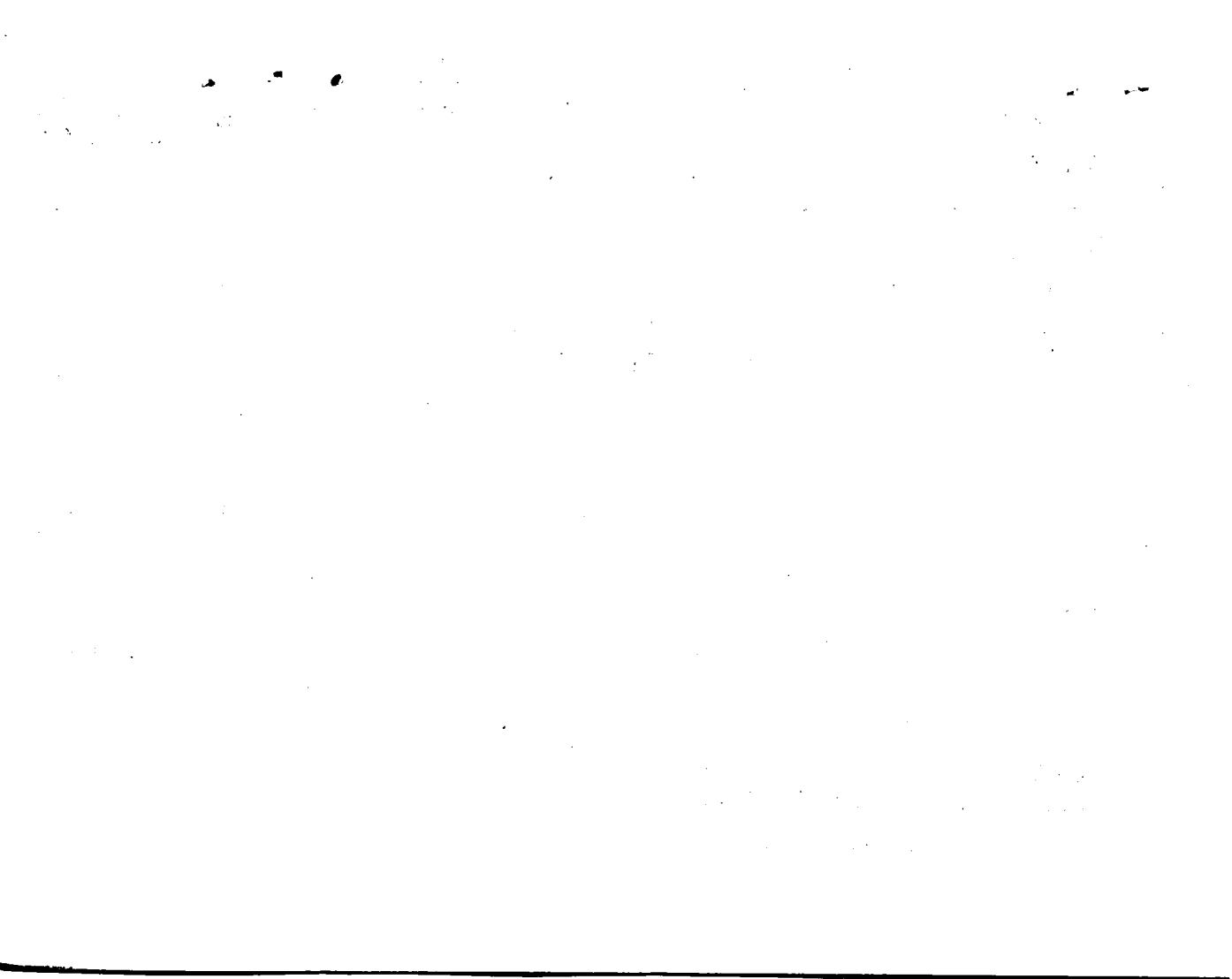
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. B. Harrison  
(Physician or midwife)

Given names added from a supplemental report.

Address Palouse Wn  
Filed Aug 8 1921 D. J. W. Thompson Registrar

Registrar



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of IdahoCity of Booth

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65Primary Registrar Dr. J. H. Blood(No. AUG 10 1921 St.)State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 34879

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

BUREAU OF VITAL

STATISTICS

(of J. H. Blood)

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

Still Born  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. da.

IF LESS than 1 day  
how many hrs.  
or min. ?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

Baby

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

J. H. Blood

## 11. BIRTHPLACE OF FATHER

(State or Country)

California

## 12. MAIDEN NAME OF MOTHER

Anna H. Thompson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Blood

(Address)

Palouse, Wash

## 15.

Filed Aug 8 1921J. W. Thompson  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Still Born Aug 6 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Still born to \_\_\_\_\_ 19\_\_\_\_

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still born(Duration) ✓ Yrs. mos. ds.Contributory  
(Secondary)(Duration) ✓ yrs. mos. ds.(Signed) Dr. J. H. Blood M. D.8/6 1921 (Address) Palouse, Wn

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? ✓Former or usual residence ✓

## 19. PLACE OF BURIAL OR REMOVAL

Palouse, Wash

## DATE OF BURIAL

Aug 7 1921

## 20. UNDERTAKER

Dr. J. H. Blood

## ADDRESS

Palouse

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

218-116029-145

PLACE OF BIRTH

County of *Idaho*City of *Moscow*No. *720 So. Main St.*Hospital *The Gutman*FULL NAME OF CHILD *Baby Layne*STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25a-4437

RECEIVED CERTIFICATE OF BIRTH

AUG 6 1921

Registration ~~BUREAU OF VITAL~~  
STATISTICSFile No. *92514*Primary Registration District No. *1011*Registered No. *116*

Sex of Child <i>Male</i>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legiti- mate? <i>Yes</i>	Date of Birth <i>July 11</i> (Month) (Day) (Year) <i>1921</i>
--------------------------	---	---------------------------------------	-----------------------------	--

FULL NAME <i>G. B. Dayles</i>	FATHER
RESIDENCE <i>Moscow, Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>33</i> (Years)
BIRTHPLACE <i>Michigan</i>	
OCCUPATION <i>Auto Mechanic</i>	

FULL MAIDEN NAME <i>Emma Junga</i>	MOTHER
RESIDENCE <i>Moscow Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>27</i> (Years)
BIRTHPLACE <i>Minnesota</i>	
OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth *1*..... Number of children of this mother now living, including present birth *0*.....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was *Stillborn*..... at *5:30 P.M.*  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *Chas. L. Gutman M.D.*

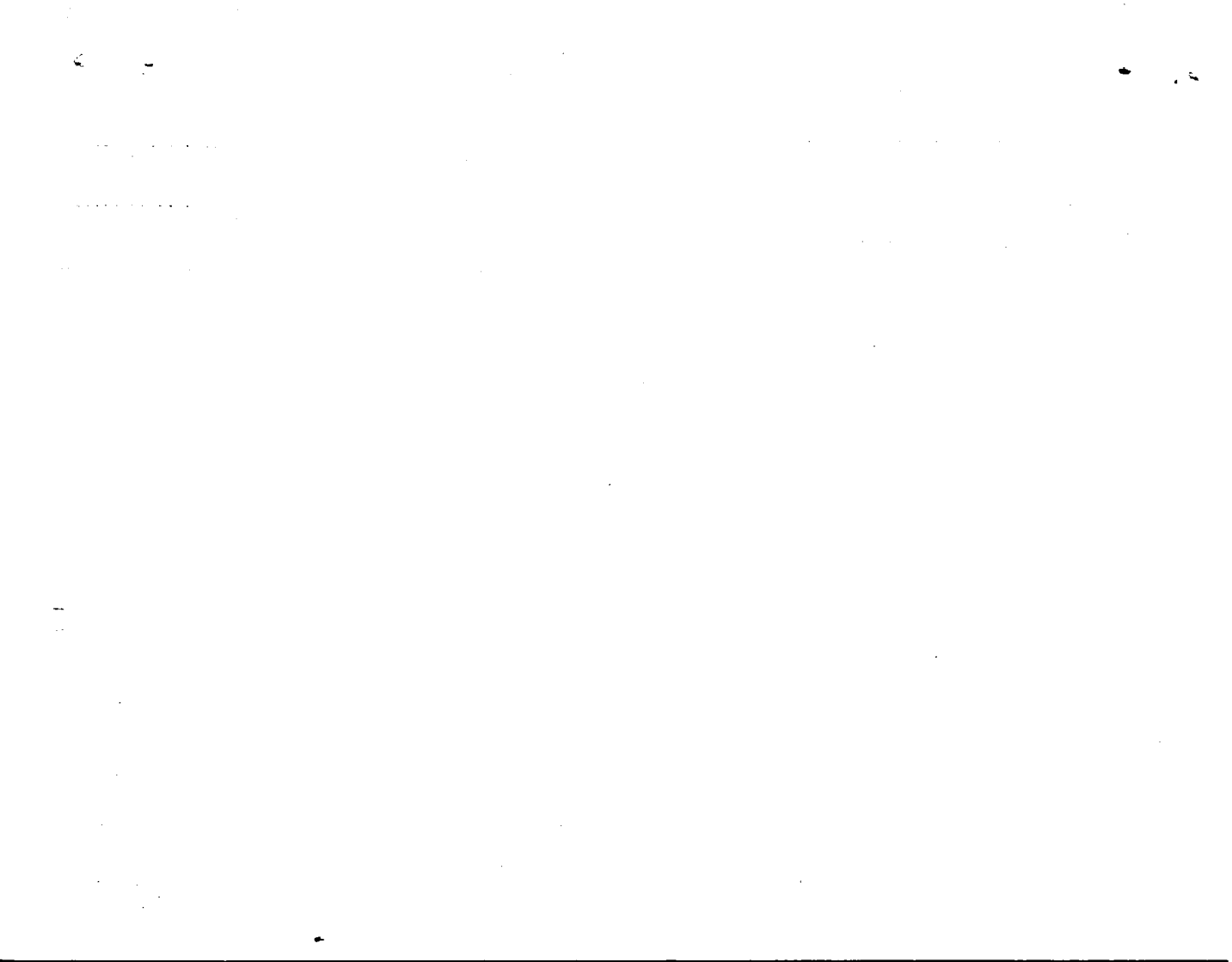
(Physician or midwife)

Given names added from a supplemental report.

Address *Moscow Idaho*Filed *July 30 1921* *W. H. Canthess*

Registrar

Registrar



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of LatahCity of Moore

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61Primary Registration District No. 1011(No. 1921 St.)File No. 34876

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

Infant of Vital Statistics  
Sayles

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

M

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

July 11 1921  
(Month) (Day) (Year)

## 7. AGE

Still born  
Yrs. Mos. ds. IF LESS than 1 day  
how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed 7/12 1921 N.H. Barthers  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

July 11 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillborn  
(Duration) Yrs. mos. ds.Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. L. Britton M.D.7/12 1921 (Address) Moore, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Moore 7/12 1921

## 20. UNDERTAKER

## ADDRESS

Glenn Grace Moore

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

962-130-029-619

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S 92526

County of Idaho

City of Bovill

No. # St.

Hospital #

FULL NAME OF CHILD

AUG 6 1921

BUREAU OF VITAL  
STATISTICS

Primary Registration District No. 2146

File No. 25

Registered No.

Sex of Child male Twin Triplet or other? (To be answered only in event of plural births) and Number in order of birth 1 Legit mate? yes Date of Birth 7-30-21 (Month) (Day) (Year)

FATHER  
FULL NAME Clayton John Robinson  
RESIDENCE Bovill  
COLOR White AGE AT LAST BIRTHDAY 28 (Years)  
BIRTHPLACE Wisconsin  
OCCUPATION Stationary Engineer

MOTHER  
FULL MAIDEN NAME Elise Warner  
RESIDENCE Bovill  
COLOR White AGE AT LAST BIRTHDAY 23 (Years)  
BIRTHPLACE Kansas  
OCCUPATION Housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 12 P. M. on the date above stated. (Born alive or stillborn)

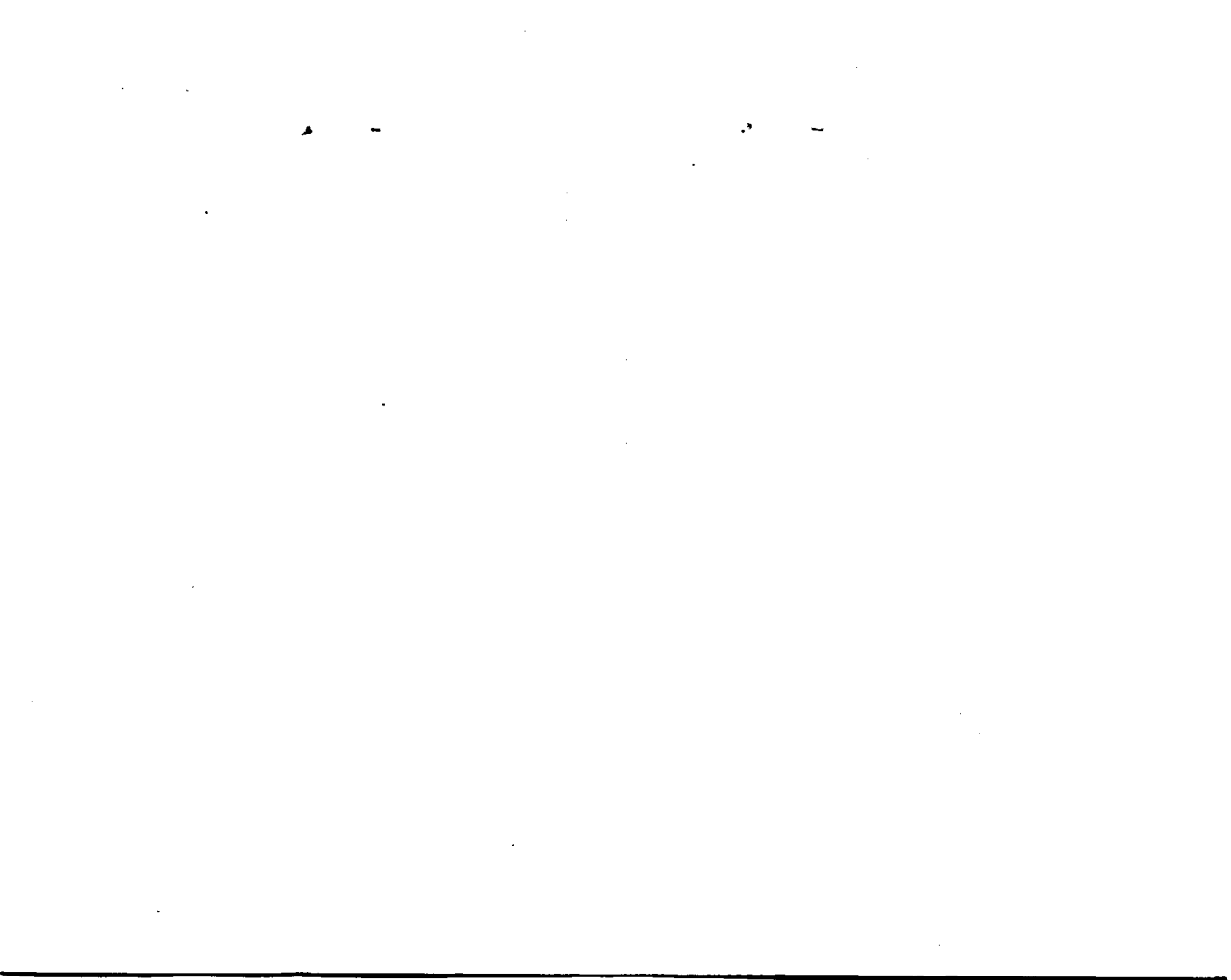
\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F. H. Gibson  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Bovill, Idaho  
Filed 7/30 1921 Wm. R. Gibson  
Registrar

Registrar



FORM V. S. No. 25 M. 1-19.

## CERTIFICATE OF DEATH

34872

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Latah*City of *Bozill*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *66*

RECEIVED

Primary Registration District No. *2146*

AUG 6 (No. 1921)

St.)

File No. *6*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

BUREAU OF VITAL  
STATISTICS

## 2. FULL NAME

*Wardner Robinson*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Single*  
(Write the word.)

## 6. DATE OF BIRTH

*July* *30* *1921*  
(Month) (Day) (Year)

## 7. AGE

*Stillborn*IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) *Idaho*

## 10. NAME OF FATHER

*Clayton John Robinson*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Wisconsin*

## 12. MAIDEN NAME OF MOTHER

*Elsie Warner*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Kansas*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs C.F. Robinson*(Address) *Bozill Idaho*

## 15.

Filed *7/30* *1921**1921**Mrs J.C. Gibson*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*July* *30* *1921*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*1921* to *1921*that I last saw him alive on *1921*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH\* was as follows:

*Stillborn*  
*Eight months Gestation*  
(Duration) Yrs. mos. ds.Contributory *Eight Mile Ride in Automobile*  
(Secondary)*roughly 10 hrs.* (Duration) yrs. mos. ds.(Signed) *J.C. Gibson* M. D.*7/30/21* (Address) *Bozill Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Bozill Idaho*

## DATE OF BURIAL

*7/21* *1921*

## 20. UNDERTAKER

*J. Fisher*

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

85-4-123-033-753  
PLACE OF BIRTH

RECEIVED

AUG 6 1921

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

BUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

S 92586

County of Madison

City of Rexburg

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 100

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2178

Registered No. 184

FULL NAME OF CHILD \_\_\_\_\_

Clyde H. Hemsley  
(Certificate of no value without full name of child.)

Sex of  
Child Male

Twin  
Triplet  
or other?

{ and }

Number  
in order  
of birth

Legiti-  
mate?

Yes

Date of  
birth

June 23rd 1921  
(Month) (Day) (Year)

(To be answered only in event of plural births)

(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth 2nd Number of child of this mother now living, including present birth None

FULL  
NAME FATHER  
Clyde D. Hemsley

FULL  
MAIDEN  
NAME MOTHER  
Alice E. Peterson

RESIDENCE Plano Idaho

RESIDENCE Plano Idaho

COLOR White AGE AT LAST  
BIRTHDAY 27  
(Years)

COLOR White AGE AT LAST  
BIRTHDAY 21  
(Years)

BIRTHPLACE Salt Lake City Utah

BIRTHPLACE Salt Lake City Utah

OCCUPATION Farmer

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still Born June 23rd 1921 4-30 A. M.  
on the date above stated. (Born alive or stillborn)

{ \*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth. }

(Signature) Parley Nelson  
M.D.  
(Physician or midwife)

Give names added from a supplemental report.

Address Rexburg Idaho  
Filed 7/20 1921 E. G. Espe  
Registrar.

SECRET

**BUREAU OF VITAL  
STATISTICS**

Boise, Idaho, .. *August 20* .. 192*1*.

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

**BUREAU OF VITAL STATISTICS.**

Place of Birth { City *Reynoldsburg, Idaho.*  
Street .....  
County *Madison.*

File Number ..... *92586* .....

Registration Dist. No. ....

Sex of Child..... *male.* .....

Date of Birth *June 23*, ..... 192*1*..

Father *Clyde Davis Hemmley*..... Mother *Glice Eugenia Hemmley*.....  
Full Name Full Maiden Name

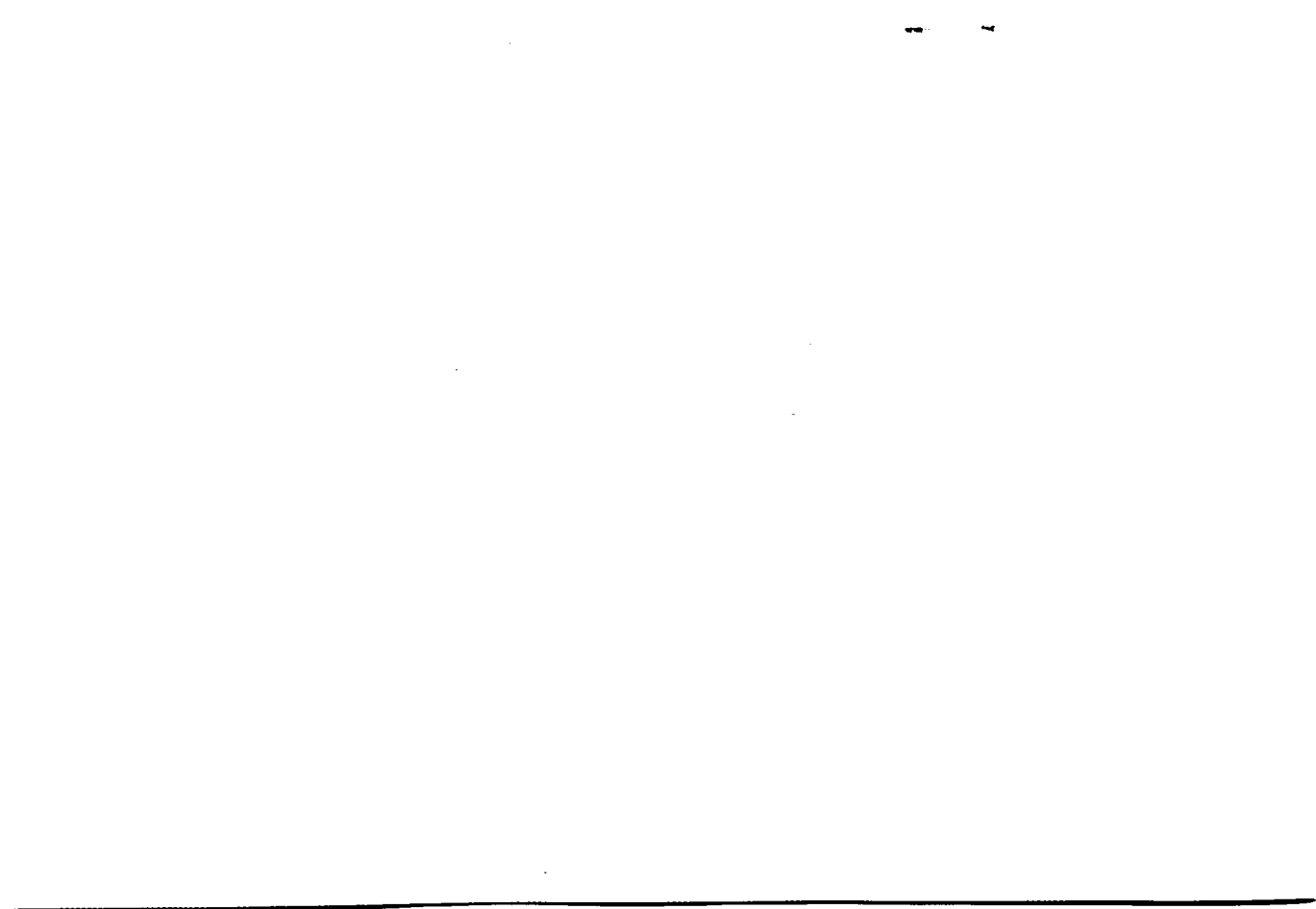
I HEREBY CERTIFY that the child described herein has been named:

..... *Clyde H. Hemmley* .....

Child's Name in Full

..... *Glice E. Hemmley* .....

Signature of Father or Mother





MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

# CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 34591

1. PLACE OF DEATH. Registration District No. 100  
County of Madison Registration District No. 2178  
City of Boise (St.)

Registered No. \_\_\_\_\_  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information. 2.

BUREAU OF VITAL STATISTICS

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married  
(Write the word.)

6. DATE OF BIRTH June 23 1921  
(Month) (Day) (Year)

7. AGE \_\_\_\_\_ IF LESS than 1 day  
how many hrs. or mins.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9. BIRTHPLACE Boise  
(State or Country)

10. NAME OF FATHER Clyde D. Hensley

11. BIRTHPLACE OF FATHER Utah  
(State or Country)

12. MAIDEN NAME OF MOTHER Alice E. Adeline

13. BIRTHPLACE OF MOTHER Utah  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Clyde D. Hensley  
(Address) R. 3

15. Filed 7/23 1921 Local Registrar W. H. Hensley

## MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 23 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1921, to June 23 1921  
that I last saw him alive on \_\_\_\_\_ 191\_\_\_\_  
and that death occurred on the date stated above, at 9 A.M.  
The CAUSE OF DEATH\* was as follows:  
Still Born

(Duration) yrs. mos. ds.  
Contributory Protrusion of Umbilical Cord  
(Secondary) \_\_\_\_\_  
(Duration) yrs. mos. ds.  
(Signed) Parley Nelson M. D.  
6-23-1921 (Address) Boise

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence. \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL Boise DATE OF BURIAL 7/23 1921

20. UNDERTAKER W. H. Hensley ADDRESS Boise

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

496-125-1833-819  
PLACE OF BIRTH

County of Madison

City of Rexburg

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

RECEIVED  
AUG 6 1921  
BUREAU OF VITAL STATISTICS

Registration District No. 100 File No. 92588

Primary Registration District No. 2178 Registered No. 182

Burl Drollinger  
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	<u>Twin</u> Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>June 25th 1921</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------	------------------------	---

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth... 1st Number of child of this mother now living, including present birth... None

FULL NAME FATHER  
C. John Drollinger

RESIDENCE Rexburg Idaho

COLOR White AGE AT LAST BIRTHDAY 19  
(Years)

BIRTHPLACE Marysville Idaho.

OCCUPATION Farmer

FULL MAIDEN NAME MOTHER  
Norma Harris

RESIDENCE Rexburg Idaho

COLOR White AGE AT LAST BIRTHDAY 18  
(Years)

BIRTHPLACE Portage Utah

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Born Dead Jun 3. 25th 1921... 1 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Parley Nelson  
M. D.  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Rexburg Idaho  
Filed 7/20 1921 G. E. E.  
Registrar.

CONFIDENTIAL

402-1000

BUREAU OF VITAL  
STATISTICS

Boise, Idaho,.....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Merburg* .....  
Street .....  
County *Madison* .....  
File Number *92585* .....  
Registration Dist. No. ....  
Sex of Child *male* ..... Date of Birth *June 25<sup>th</sup>* 192*6* .....  
Father *Cecil John Drollinger* ..... Mother *Norma Harris* .....  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Cecil Drollinger* .....  
Child's Name in Full  
*C. J. Drollinger* .....  
Signature of Father or Mother



WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

238-124-  
035 PLACE OF BIRTH

RECEIVED  
AUG 5 1921  
BUREAU OF VITAL STATISTICS

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

County of... *Nezperce*...  
City of... *Lewiston*...  
No. .... St. ....  
Hospital... *Whites*...  
Registration District No. .... *96*...  
Primary Registration District No. .... *1009*...  
File No. .... *S 92644*...  
Registered No. .... *716*...

FULL NAME OF CHILD... *Joe Bly*...

Sex of Child... <i>M.</i>	Twin Triplet or other? <i>and</i>	Number in order of birth <i>1</i>	Legitimate? <i>yes</i>	Date of Birth... <i>6 - 24</i> 19 <i>21</i> (Month) (Day) (Year)
---------------------------	-----------------------------------	-----------------------------------	------------------------	---

FULL NAME... <i>Joe Bly</i>	FATHER	FULL MAIDEN NAME... <i>Addie Rose</i>	MOTHER
RESIDENCE... <i>Bly Wn.</i>		RESIDENCE... <i>Bly Wn.</i>	
COLOR... <i>W.</i>	AGE AT LAST BIRTHDAY... <i>22</i> (Years)	COLOR... <i>W.</i>	AGE AT LAST BIRTHDAY... <i>25</i> (Years)
BIRTHPLACE... <i>Wn.</i>		BIRTHPLACE... <i>Wn.</i>	
OCCUPATION... <i>Homesteader</i>		OCCUPATION... <i>Home wife</i>	

Number of child of this mother, including present birth... / ... Number of children of this mother now living, including present birth... / ...

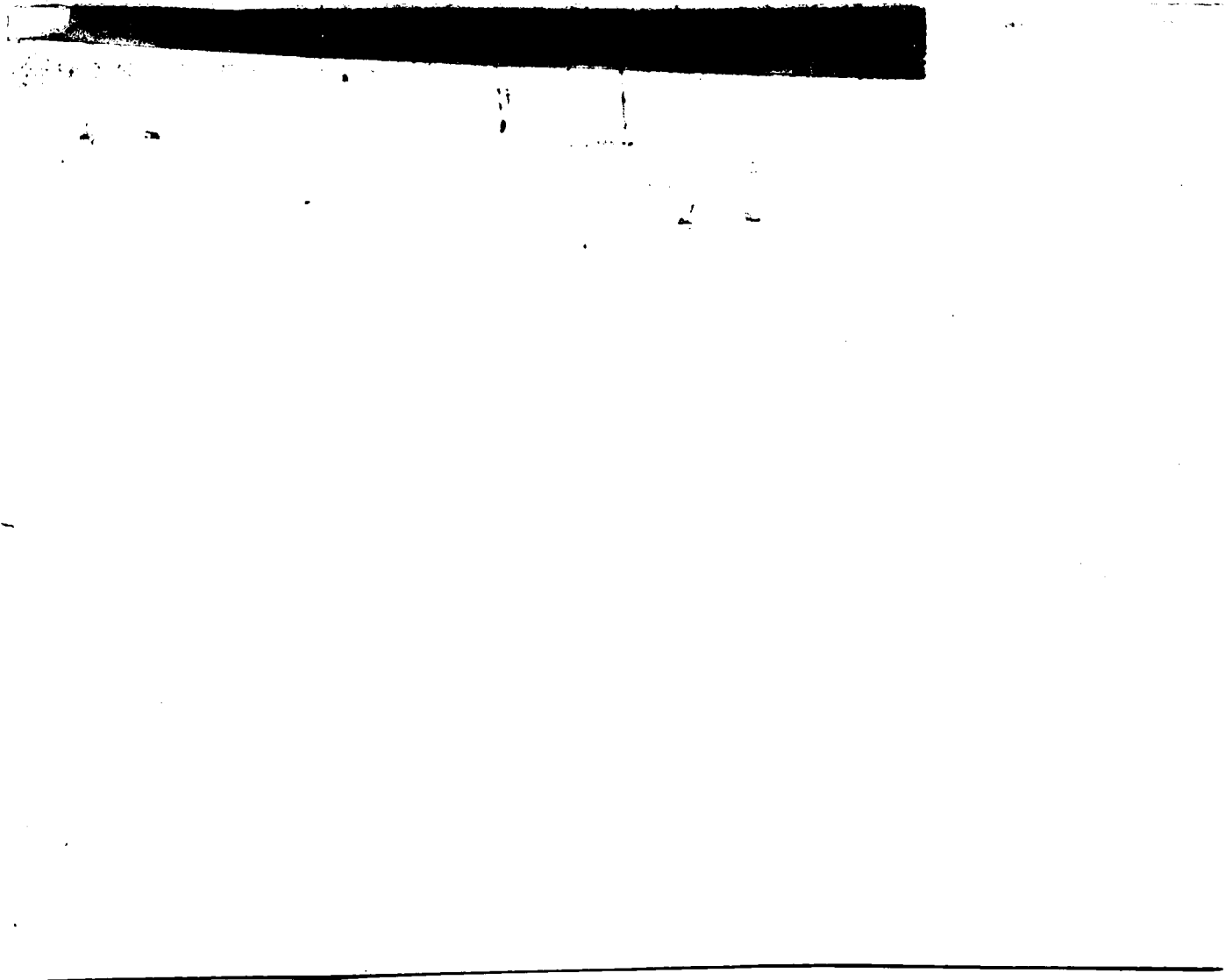
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was... *still born*... at *12* P. M.  
(Born alive or stillborn)

(Signature) ... *W. McManis* ...  
... *Lu D.* ...  
(Physician or midwife)

Given names added from a supplemental report.

Address... *Lewiston, Ida.*...  
Filed... *July 30, 1921*...  
Registrar... *Nisan E. Bunn*...  
Registrar





FORM V. S. No. 5-A—25 M. 1-19.

## 1. PLACE OF DEATH

County of *Blaine*City of *Leicester*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

## CERTIFICATE OF DEATH

Registration District No. *96*Primary Registration District No. *1009*

BUREAU OF VITAL STATISTICS

## 2. FULL NAME

*(Infant) Bly*State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *34920*Registered No. *666*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Single*  
(Write the word.)

## 6. DATE OF BIRTH

*June 25 1921*  
(Month) (Day) (Year)

## 7. AGE

*Stillbirth*  
Yrs. mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

*Inf.*

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*Jas. S. Bly*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Idaho*

## 12. MAIDEN NAME OF MOTHER

*Addie Case*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Jos. S. Bly*  
*Rogers Bly*

(Address)

## 15.

Filed *July 31 1921**Wm. E. Bruce*  
Local Registrar

SYMS-YORK CO. PRINTERS &amp; BINDERS, BOISE 51087

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*June 25 1921*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*at birth 19 to 6-25-1921*that I last saw him *alive on stillborn* 19and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH\* was as follows:

*Cause not known full term*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. F. McDonald* M. D.*6-27 1921* (Address) *Leicester*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

*Leicester Ida*

## DATE OF BURIAL

*6/25/21*

## 20. UNDERTAKER

*Vassar and Co.*

## ADDRESS

*Leicester*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

335-1031035-343

PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of *My River*

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
AUG 5 1921  
BIRTH  
Registration District No. *92*

S 92659

City of *Summit*

No. \_\_\_\_\_ St.

Primary Registration District No. *2170*

Registered No. *13*

Hospital \_\_\_\_\_

FULL NAME OF CHILD

*Marvin Cleveland*

Sex of Child <i>M</i>	Twin Triplet <i>2</i> or other? <i>2</i> (To be answered only in event of plural births)	and	Number in order of birth <i>2</i>	Legiti mate? <i>yes</i>	Date of Birth <i>7 3 1921</i> (Month) (Day) (Year)
-----------------------	---	-----	---	----------------------------	--

FATHER  
FULL NAME *Charles Cleveland*  
RESIDENCE *Summit*  
COLOR *Wh* AGE AT LAST BIRTHDAY *42* (Years)  
BIRTHPLACE *Tenn*  
OCCUPATION *farmer*

MOTHER  
FULL MAIDEN NAME *Alice J. Tucker*  
RESIDENCE *Summit*  
COLOR *Wh* AGE AT LAST BIRTHDAY *31* (Years)  
BIRTHPLACE *Ida*  
OCCUPATION *house*

Number of child of this mother, including present birth *5* Number of children of this mother now living, including present birth *4*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was *still born* at *11:00 a* M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *E. E. Watts*

(Physician or midwife)

Given names added from a supplemental report.

19

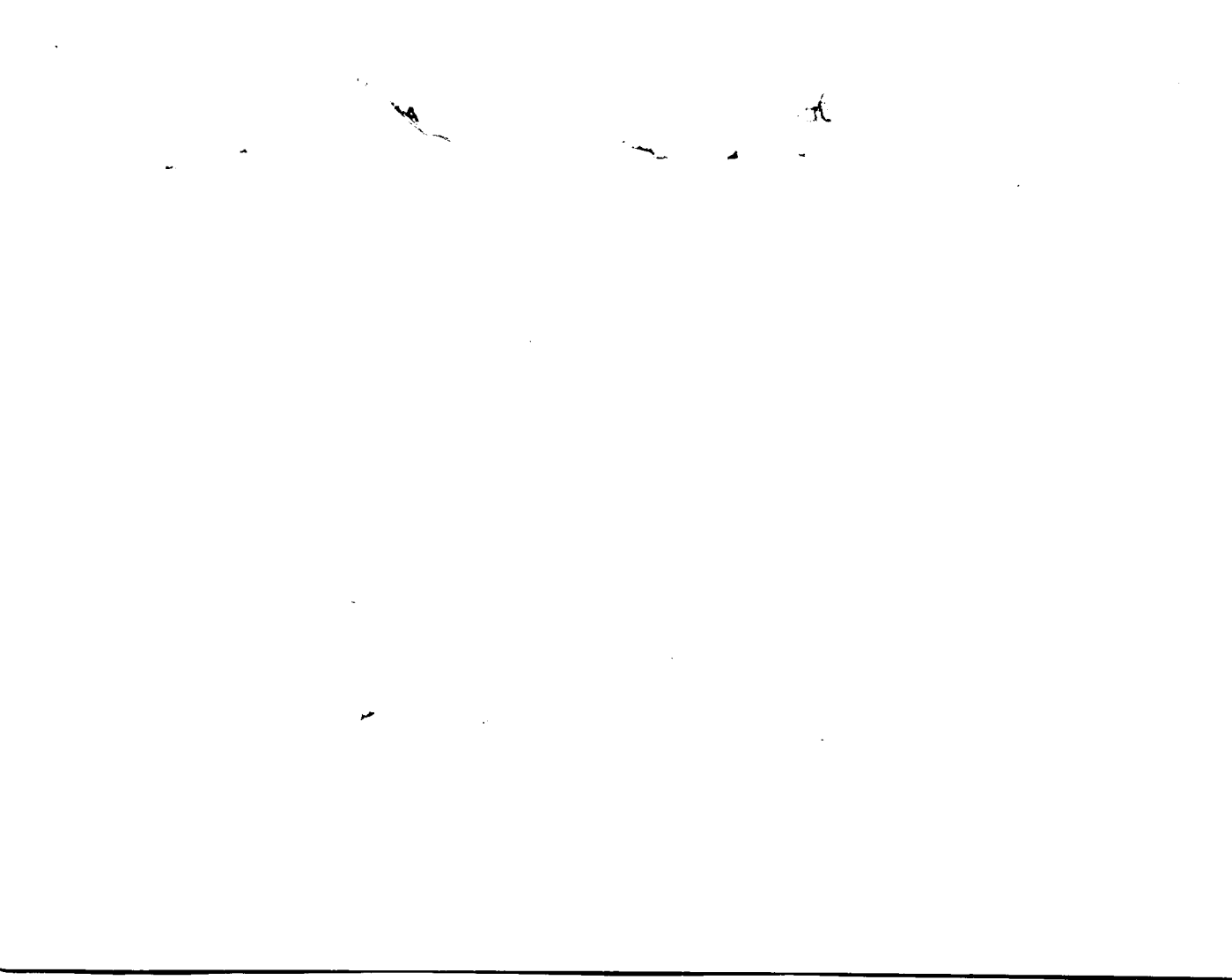
Address \_\_\_\_\_

Filed *7-3 1921*

*E. E. Watts*

Registrar

Registrar



Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

## BUREAU OF VITAL STATISTICS.

Place of Birth { City Summit, P.O.  
 Street .....  
 County Myer

File Number .....72659.....

Registration Dist. No. ....

Sex of Child male Date of Birth July 3 1924

Father Charles F. Cleveland Mother Alice J. Cleveland  
 Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Maurice Cleveland  
 Child's Name in Full

Alice J. Cleveland  
 Signature of Father or Mother



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-11

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *My Perce* Registration District No. *92*  
City of *Summit* Registration District No. *2170*  
St. *Idaho*

34914

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. *35*  
Registered No. *26*

If death occurs away from  
usual residence, give facts  
called for under special  
information.

2. FULL NAME

*infant Cleveland*

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*M*

4. COLOR OR RACE

*W*5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.*single*  
(Write the word.)

6. DATE OF BIRTH

*7* *3* *1921*  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or  
min.?

8. OCCUPATION

(a) Trade, profession or  
particular kind of work...  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which employ-  
ed (or employer).....

9. BIRTHPLACE

(State or Country)

*Ida*10. NAME OF  
FATHER*Chas F. Cleveland*11. BIRTHPLACE  
OF FATHER

(State or Country)

*Ida*12. MAIDEN NAME  
OF MOTHER*Alice J. Tucker*13. BIRTHPLACE  
OF MOTHER

(State or Country)

*Ida*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *C. F. Cleveland*(Address) *Summit*

15.

Filed *7-3* *1921**E. E. Watts*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*7* *3* *1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at *11:30 A.M.*

The CAUSE OF DEATH\* was as follows:

*still born*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. E. Watts* M. D.

19 (Address)

\*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1)  
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place In the  
of death yrs. mos. days State yrs. mos. days

Where was disease contracted  
if not at place of death?Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

*Gifford*

DATE OF BURIAL

*7-4 1921*

20. UNDERTAKER

*W. E. Stoddard*

ADDRESS

*Gifford*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



**FILE # 92662**

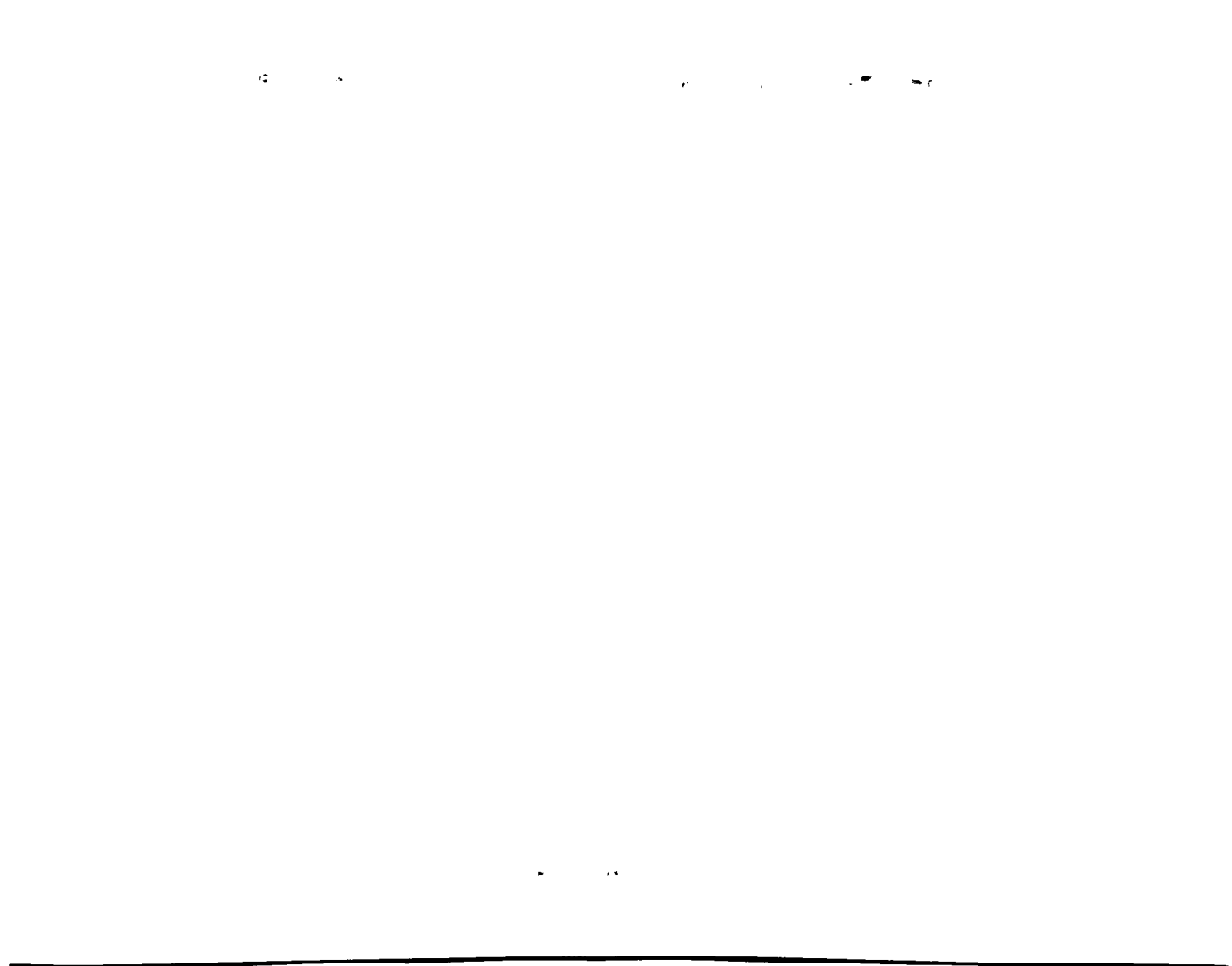
**YEAR 1921**

**IDAHO STILLBIRTH CERTIFICATE**



**VOID DUP OF 1921-91850**

**STILLBIRTH**



815-122-039-819

PLACE OF BIRTH

County of Power  
City of Ames Falls

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

StillbornSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS

RECEIVED

AUG 10 1921  
BUREAU OF VITAL STATISTICS

Registration District No. \_\_\_\_\_

Primary Registration District No. 2072

Form V. S. No. 11-C—Rev-9-8-15

S 92702  
7

File No. \_\_\_\_\_

Registered No. 323

Sex of Child <u>Male</u>	Twin Triplet or other? <u>—</u> and { Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of Birth <u>May 28 1921</u> (Month) (Day) (Year)
FULL NAME <u>Mark C. Clanger</u> FATHER		FULL MAIDEN NAME <u>Mabel Harrison</u> MOTHER	
RESIDENCE <u>Ames Falls</u>		RESIDENCE <u>Same</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Ida</u>	
OCCUPATION <u>Farmer</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth. 10Number of children of this mother now living, including present birth. 4

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Stillborn  
(Born alive or stillborn)at 11:50 A.M.

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

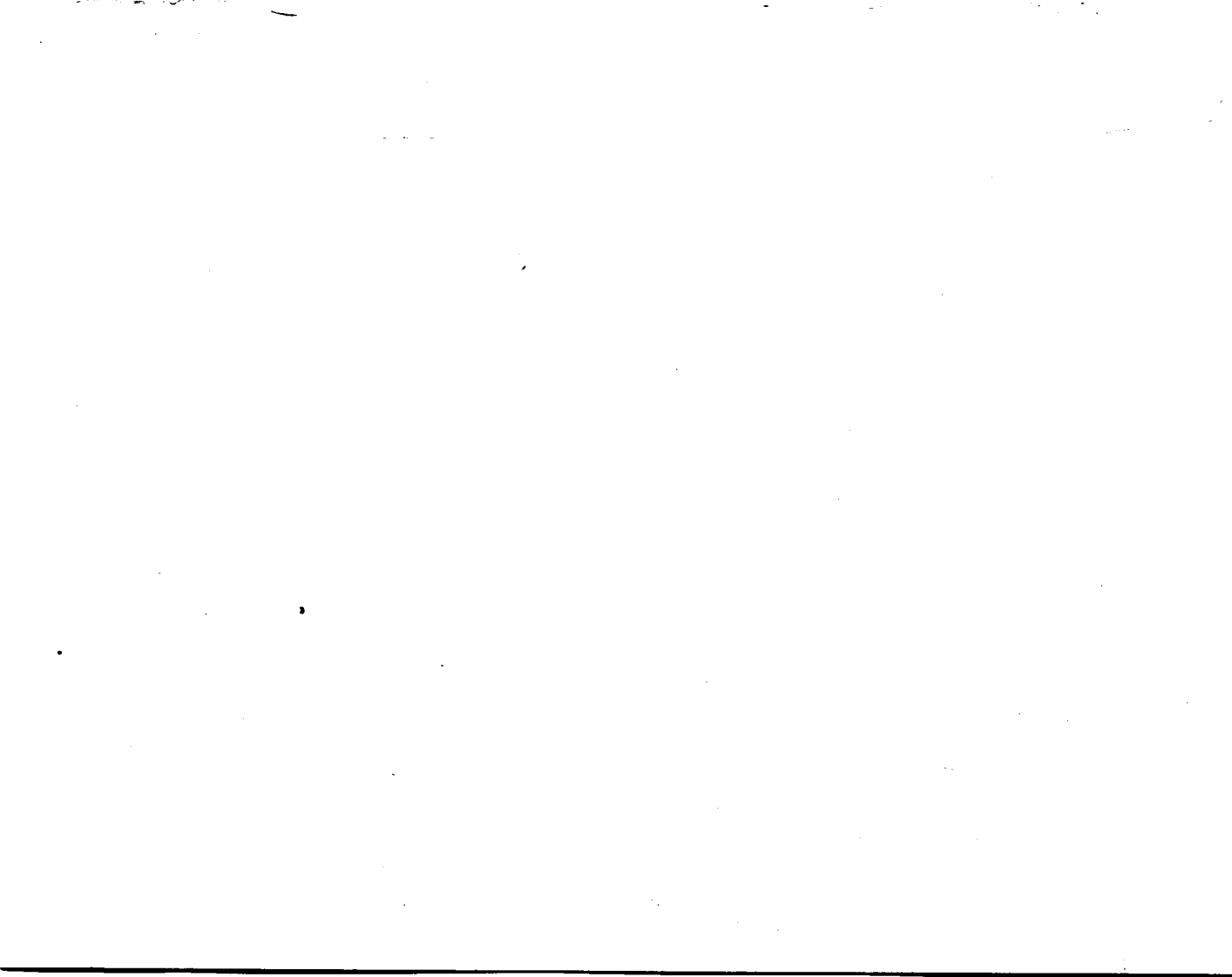
(Signature) C. F. Schuey M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address Ames Falls, Ida.Filed 8-2 19 21R. J. North

Registrar



# BUREAU OF VITAL STATISTICS

Boise, Idaho,

Aug 27

1921

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place

City

American Falls

of

Street

Birth

County

Power

File Number

92702

Registration Dist. No.

Sex of Child

male

Date of Birth

May 28

1921

Father

Mark Elmer Stanger

Full Name

Mother

Mabell Harrison

Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

It was still birth, not named.

Child's Name in Full

Mr. M. E. Stanger

Signature of Father or Mother

ND

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

249-110 039-966

## PLACE OF BIRTH

County of 2<sup>nd</sup> W

City of \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Not namedSex of  
ChildmaleTwin  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti  
mate?yesDate of  
BirthJuly 10  
(Month) (Day)1921  
(Year)FULL  
NAMEEarl D. Smith

FATHER

RESIDENCE

Winnebago, Nev.

COLOR

WhiteAGE AT LAST  
BIRTHDAY38  
(Years)

BIRTHPLACE

American Falls, Idaho

OCCUPATION

ClerkFULL  
MAIDEN  
NAMENina Rowley

MOTHER

RESIDENCE

Winnebago, Nev.

COLOR

WhiteAGE AT LAST  
BIRTHDAY33  
(Years)

BIRTHPLACE

Soda Springs, Idaho

OCCUPATION

HousewifeNumber of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 11 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

V.G. Logan

(Physician or midwife)

Given names added from a supplemental report.

19

Address

American Falls, Idaho

Filed

8-2 19 2/18 R. J. North

Registrar

Registrar

RECEIVED  
BUREAU OF VITAL STATISTICS  
AUG 10 1921  
BUREAU OF VITAL  
STATISTICS

Form V. S. No. 11-C-25m-7-21-19

S 92710

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. 2072Registered No. 313





WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

632-107-009-000  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED  
AUG 18 1921

CERTIFICATE OF BIRTH

S 92818

County of Bonne

City of Sanford

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Registration District No. 78  
BUREAU OF VITAL STATISTICS

Primary Registration District No. 2155

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>—</u> } and { Number in order of birth <u>—</u>	Legiti- mate? <u>yes</u>	Date of birth <u>7-7</u> 192 <u>1</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER  
FULL NAME Hans Olestead  
RESIDENCE Sanford  
COLOR white AGE AT LAST BIRTHDAY \_\_\_\_\_ (Years)  
BIRTHPLACE \_\_\_\_\_  
OCCUPATION farmer

MOTHER  
FULL MAIDEN NAME \_\_\_\_\_  
RESIDENCE Sanford  
COLOR white AGE AT LAST BIRTHDAY \_\_\_\_\_ (Years)  
BIRTHPLACE \_\_\_\_\_  
OCCUPATION h.s.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

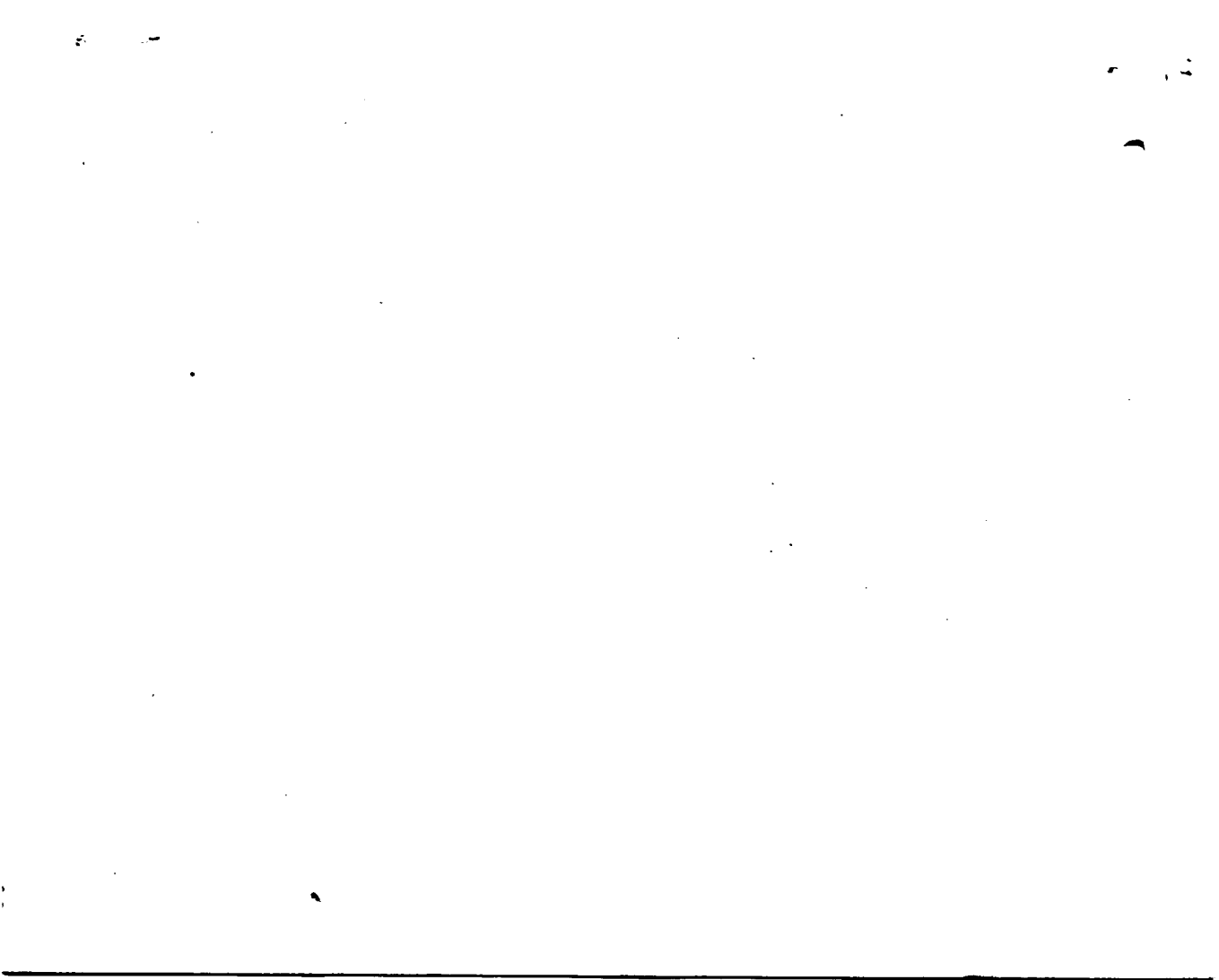
I hereby certify that I attended the birth of this child, who was stillborn at 4 m. a. m.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature) H. R. Hollister  
\_\_\_\_\_  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Sanford  
Filed Aug 13 1921 H. R. Hollister  
Registrar.



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Bonanza*City of *Sand Point*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *78*Primary Registration District No. *2153*(No. *Boyer*)

## 2. FULL NAME

*(Infant V.) Olsdal*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Single* (Write the word.)

## 6. DATE OF BIRTH

*July 7, 1921*  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) *Ida*

## 10. NAME OF FATHER

*Klaus Olsdal*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Norway*

## 12. MAIDEN NAME OF MOTHER

*Kater Petersen*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Norway*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Klaus Olsdal*(Address) *Sand Point, Ida*

## 15.

Filed *July 8, 1921**1921**Floyd E. Olsdal*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*July 7, 1921*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

*Stroke* to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Stroke, prolonged labor*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *S. P. Hallentine*

M. D.

*July 7, 1921* (Address) *Sand Point, Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*On beach, on Boyer July 7, 1921*

## 20. UNDERTAKER

*B. K. Jorgensen*

ADDRESS

State of Idaho  
BOARD OF HEALTH  
Vital Statistics  
RECEIVED  
File No. 1921 34743  
AUG 18 1921  
BUREAU OF VITAL STATISTICS  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

187

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

666 - 201 - 009 - 666  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED  
AUG 18 1921

CERTIFICATE OF BIRTH

S92825

County of Banner

City of Sage

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

BUREAU OF VITAL  
STATISTICS

Primary Registration District No. 213

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

FULL NAME OF CHILD Stellborn

(Certificate of no value without full name of child.)

Sex of Child <u>female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>5-1</u> 192 <u>1</u> (Month) (Day) (Year)
----------------------------	---	-----------	--------------------------------	------------------------	---

What bacteriocidal solution was used in eyes? Stellborn

Number of child of this mother, including present birth. \_\_\_\_\_ Number of child of this mother now living, including present birth. \_\_\_\_\_

FATHER  
FULL NAME Henry David Woodward  
RESIDENCE Sage  
COLOR W. AGE AT LAST BIRTHDAY 38  
(Years)  
BIRTHPLACE Kan  
OCCUPATION farmer

MOTHER  
FULL MAIDEN NAME Maud Woodward  
RESIDENCE Sage  
COLOR W AGE AT LAST BIRTHDAY 32  
(Years)  
BIRTHPLACE Mo  
OCCUPATION House

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

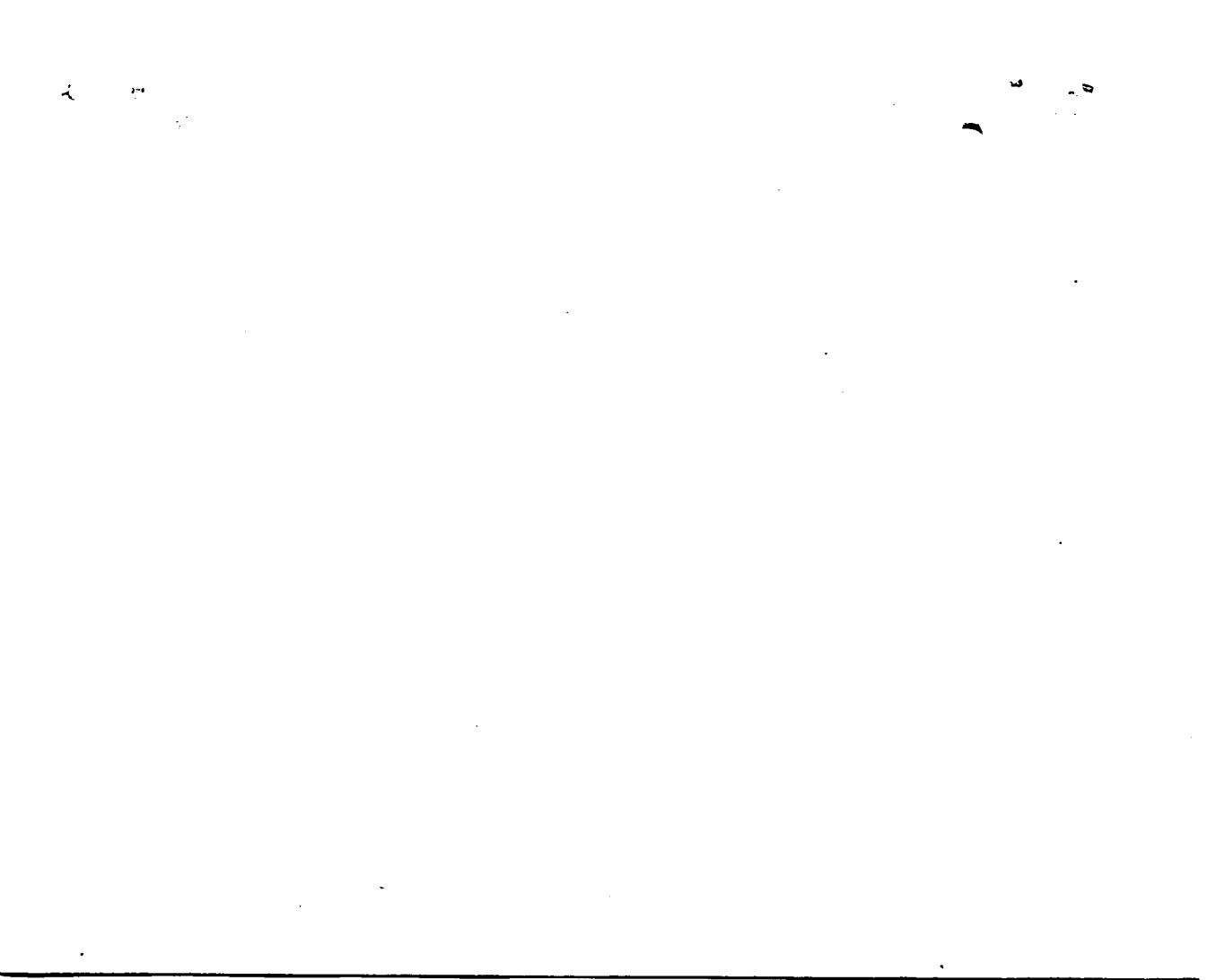
I hereby certify that I attended the birth of this child, who was Stellborn at 12:10 M  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. P. Chalkley  
(Physician or midwife)

Give names added from a supplemental report.

Address \_\_\_\_\_  
Filed June 8 1921 Hyndman  
Registrar.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Banner  
City of SageRegistration District No. 78Primary Registration District No. 218

(No. \_\_\_\_\_)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Still bornRECEIVED  
AUG 18 1921  
BUREAU OF VITAL STATISTICSFile No. 34731

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

female white

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single  
(Write the word.)

## 6. DATE OF BIRTH

May 1 1921  
(Month) (Day) (Year)

## 7. AGE

still born Mos. \_\_\_\_\_ ds. \_\_\_\_\_IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work. \_\_\_\_\_

(b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

Henry David Bow

## 11. BIRTHPLACE OF FATHER

(State or Country) Kan.

## 12. MAIDEN NAME OF MOTHER

Maud Woodruff

## 13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry David Bow  
(Address) Sage Ida.

## 15.

Filed June 8 1921Thos. W. ...  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

May 1 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

still born to \_\_\_\_\_ 19 \_\_\_\_\_

that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

\_\_\_\_\_  
(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory  
(Secondary) \_\_\_\_\_\_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) H. P. Woodruff M. D.5-2-1921 (Address) Sagepoint Id.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

Sage

## DATE OF BURIAL

5-1-1921

## 20. UNDERTAKER

none

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

189



295-102-007-386

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of Blaine

RECEIVED

CERTIFICATE OF BIRTH

S 92926

City of Beaumont AUG 29 1921

Registration District No. 57

File No.

No.

St. STATISTICS

Primary Registration District No. 2022 Registered No. 47

Hospital

FULL NAME OF CHILD

Stillborn

Sex of Child <u>Male</u>	Twin Triplet or other? <u>  </u>	and	Number in order of birth <u>  </u>	Legitimacy? <u>Yes</u>	Date of Birth <u>July 2</u> 19 <u>21</u> (Month) (Day) (Year)
--------------------------	----------------------------------	-----	------------------------------------	------------------------	--

FATHER  
FULL NAME John A. Breashear

MOTHER  
FULL MAIDEN NAME Delila Thonander

RESIDENCE Beaumont, Ida

RESIDENCE Beaumont, Ida

COLOR white AGE AT LAST BIRTHDAY 27  
(Years)

COLOR white AGE AT LAST BIRTHDAY 21  
(Years)

BIRTHPLACE Idaho

BIRTHPLACE Utah

OCCUPATION Printer

OCCUPATION Housewife

Number of child of this mother, including present birth. 1 Number of children of this mother now living, including present birth. 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Robert H. Wright, M.D.

(Physician or midwife)

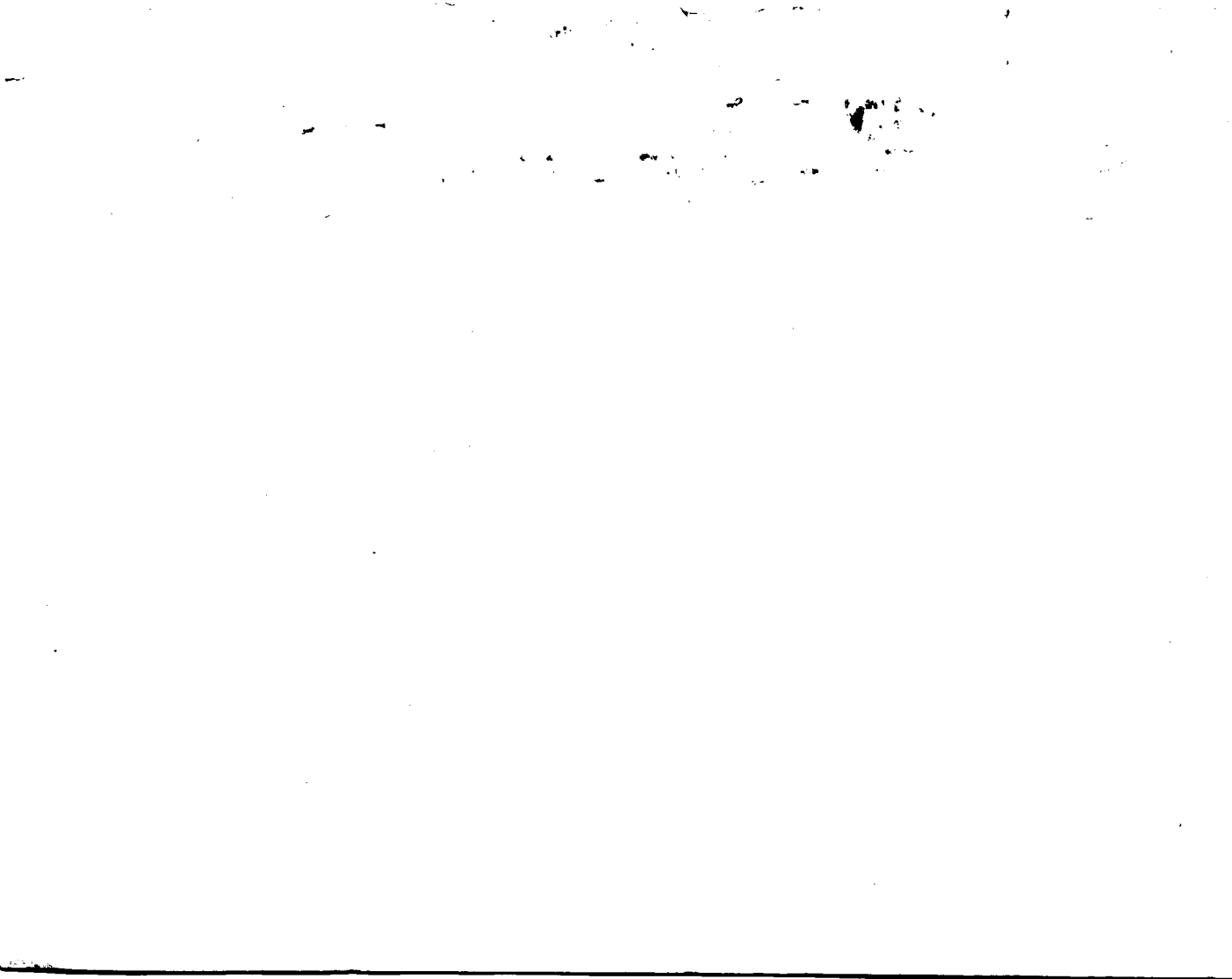
Given names added from a supplemental report.

Address Hailey, Ida

Filed Aug. 1 1921 Robert H. Wright  
Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Blaine Registration District No. 57  
City of Bellvue Registration District No. 2022 St.File No. 35000  
Registered No. 35000

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Brashears

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

## 6. DATE OF BIRTH

July 2, 1921  
(Month) (Day) (Year)

## 7. AGE

Stillborn  
Yrs. Mos. ds. IF LESS than 1 day  
how many hrs. or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Ida.

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country) Bellvue

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country) Ida.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. John D. Harris  
(Address) Bellvue, Ida.

## 15. Filed

July 20, 1921 R. H. Wright  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

11 night  
July 2, 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19... to 19...  
that I last saw him alive on 19...  
and that death occurred on the date stated above, at... M.

The CAUSE OF DEATH\* was as follows:

Stillborn  
(Duration) Yrs. mos. ds.Contributory  
(Secondary)(Duration) yrs. mos. ds.  
(Signed) Robert H. Wright M. D.  
7-3-21 (Address) Hailey, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Bellvue, Ida 7-3-1921

## 20. UNDERTAKER

R. D. Harris Hailey

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

666-105-010-294

PLACE OF BIRTH

RECEIVED

AUG 27 1921

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-1-1-18

County of Bernenville

BUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

City of Heon

Registration District No. 73

File No. **S 92968**

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 250

Registered No. 170

Hospital Home

FULL NAME OF CHILD \_\_\_\_\_ (Little Girl)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legit- imate	yes	Date of Birth <u>July 5</u> 19 <u>21</u> (Month) (Day) (Year)
FATHER				MOTHER		
FULL NAME <u>Lewell Nancy Woolf</u>				FULL MAIDEN NAME <u>Dora Simmons</u>		
RESIDENCE <u>Heon Ida</u>				RESIDENCE <u>Heon Ida</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)		COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>25</u> (Years)			
BIRTHPLACE <u>Idaho</u>				BIRTHPLACE <u>Idaho</u>		
OCCUPATION <u>Farmer</u>				OCCUPATION <u>Housewife</u>		

Number of child of this mother, including present birth. 1 Number of children of this mother now living, including present birth. 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

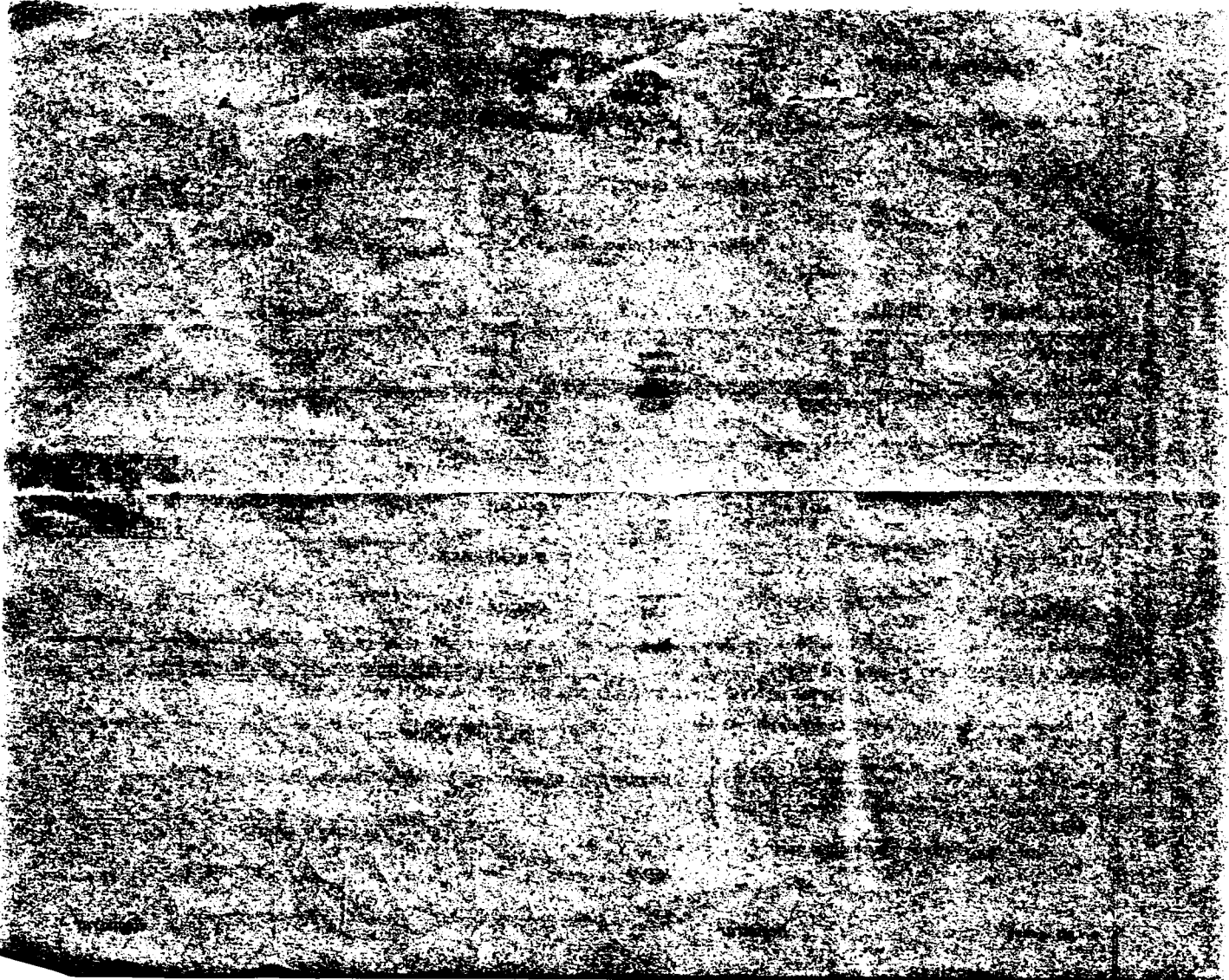
I hereby certify that I attended the birth of this child, who was still born at 1:45 P.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. J. Simmons  
midwife  
(Physician or midwife)

Given names added from a supplemental report.

Address Heon Ida  
Filed July 14 1921 W. M. Munn  
Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED  
AUG 27 1921

Registration District No. 73

County of Bonanza

Primary Registration District No. 214-0

City of Heon

BUREAU OF VITAL STATISTICS

St.

File No. 35010

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

child - Elm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male

white

(Write the word.)

6. DATE OF BIRTH

July

5

1921

(Month)

(Day)

(Year)

7. AGE

Elm

yrs.

mos.

ds.

IF LESS than 1 day  
how many hrs. or  
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Lowell Hancey Woolf

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Dora Simmons

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. J. Simmons

(Address)

Heon Id.

15.

Filed

July 14

1921

Local Registrar

16. DATE OF DEATH

July

5

1921

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Premature, Stillborn

No medical attendance

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

19

(Address)

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Heon Cemetery

July 5 1921

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

159-6



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

419-119-003-319

PLACE OF BIRTH

RECEIVED STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Bannock

SEP 15 1921 CERTIFICATE OF BIRTH

S 93288

City of Lava Hot Springs

BUREAU OF VITAL

Registration District No.

28

File No.

74

No. \_\_\_\_\_ St.

Primary Registration District No. 2161

Registered No. 3946

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Sex of Child <u>boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legiti mate? <u>yes</u>	Date of Birth <u>Aug 19</u> 19 <u>21</u> (Month) (Day) (Year)
-------------------------	---	-----	---	-------------------------------	--

FATHER  
FULL NAME Thomas Marshall  
RESIDENCE Lava Hot Springs  
COLOR white AGE AT LAST BIRTHDAY 27  
(Years)  
BIRTHPLACE Scotland  
OCCUPATION Carpenter

MOTHER  
FULL MAIDEN NAME Esther Carter  
RESIDENCE Lava Hot Springs  
COLOR white AGE AT LAST BIRTHDAY 21  
(Years)  
BIRTHPLACE Wyoming  
OCCUPATION housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 3:00 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

William J. McCall

Phys. & Surg.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

McCall

Filed

9/1 19 1

Registrar

Registrar



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

194-211-003-533

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Bannock OCT 3 1921

CERTIFICATE OF BIRTH

City of Robin BUREAU OF VITAL

Registration District No. 83

File No. S 93357

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2160

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>Female</u>	Twin <u>Triplet</u> <u>or other?</u> (To be answered only in event of plural births)	and	Number in order of birth <u>2<sup>d</sup></u>	Legitimate? <u>Yes</u>	Date of Birth <u>May 11</u> 19 <u>21</u> (Month) (Day) (Year)
----------------------------	---	-----	---	------------------------	--

FATHER  
FULL NAME Price J. Armstrong  
RESIDENCE Robin, Ida.  
COLOR W AGE AT LAST BIRTHDAY 29 (Years)  
BIRTHPLACE Virginia, Ida.  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Rebecca Ellis  
RESIDENCE Robin  
COLOR W AGE AT LAST BIRTHDAY 26 (Years)  
BIRTHPLACE Sagan, Neb  
OCCUPATION Housewife.

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 4 months gestation at 6:40 A. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

Registrar

Registrar



194-211-003-533

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

BUREAU OF VITAL STATISTICS

County of Bannock

OCT 3 1921

CERTIFICATE OF BIRTH

City of Robin

BUREAU OF VITAL

STATISTICS

Registration District No. 83File No. S93358

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2160

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

ShelbornSex of Child FemaleTwin Triplet or other?

and

Number in order of birth

Legiti mate? yesDate of Birth 5-11-21

(Month) (Day) (Year)

(To be answered only in event of plural births)

FULL NAME

Price, Armstrong

FATHER

RESIDENCE

Robin, Idaho

FULL MAIDEN NAME

Rebecca Ellis

MOTHER

RESIDENCE

Robin, Idaho

COLOR

wd

AGE AT LAST BIRTHDAY

29

(Years)

COLOR

wd

AGE AT LAST BIRTHDAY

26

(Years)

BIRTHPLACE

Virginia Sta

BIRTHPLACE

Sogan, Utah.

OCCUPATION

Farmer

OCCUPATION

no wifeNumber of child of this mother, including present birth 3Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Bonnie at 6:30 A.M.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

R. J. Hartigan

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Blawney, Idaho

Filed

5-11-21

19

Registrar

Registrar

APR 11

4.10

1911

THE JOURNAL

OF THE

ROYAL SOCIETY

RECEIVED . STATE OF IDAHO  
NOV 28 1921 DEPT. OF PUBLIC WELFARE  
BUREAU OF VITAL  
STATISTICS

Boise, Idaho, ..... October 27, ..... 1921

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City ..... Robin Idaho ..... File Number ..... 93358 .....  
Street .....  
County ..... Benewah .....  
Sex of Child ..... Female .....  
Date of Birth ..... May 11 ..... 1921 .....  
Father ..... Price Jackson Armstrong ..... Full Name  
Mother ..... Rebecca Henderson Elli ..... Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

..... Willborne .....  
Child's Name in Full  
..... Rebecca Armstrong .....  
Signature of Father or Mother





N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

597-131-005-236

PLACE OF BIRTH

County of BenedictCity of St. Maries

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

RECEIVED  
SEP 15 1921  
BUREAU OF VITAL STATISTICS  
STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Registration District No. \_\_\_\_\_

32

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

2049

Registered No. \_\_\_\_\_

85-

S 93378

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth 11	Legiti- mate? <u>yes</u>	Date of Birth <u>Aug 31</u> 19 <u>21</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------------	-----------------------------	--

FATHER  
FULL NAME Fred Vigue  
RESIDENCE St. Maries  
COLOR white AGE AT LAST BIRTHDAY 47  
(Years)  
BIRTHPLACE Wisconsin  
OCCUPATION mill work

MOTHER  
FULL MAIDEN NAME May Slovick  
RESIDENCE St. Maries  
COLOR white AGE AT LAST BIRTHDAY 38  
(Years)  
BIRTHPLACE Michigan  
OCCUPATION housewife

Number of child of this mother, including present birth, \_\_\_\_\_

11

Number of children of this mother now living, including present birth \_\_\_\_\_

7

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_  
on the date above stated.

(Born alive or stillborn)

at 12<sup>30</sup> M.

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

Do Not

(Physician or midwife)

Given names added from a supplemental report.

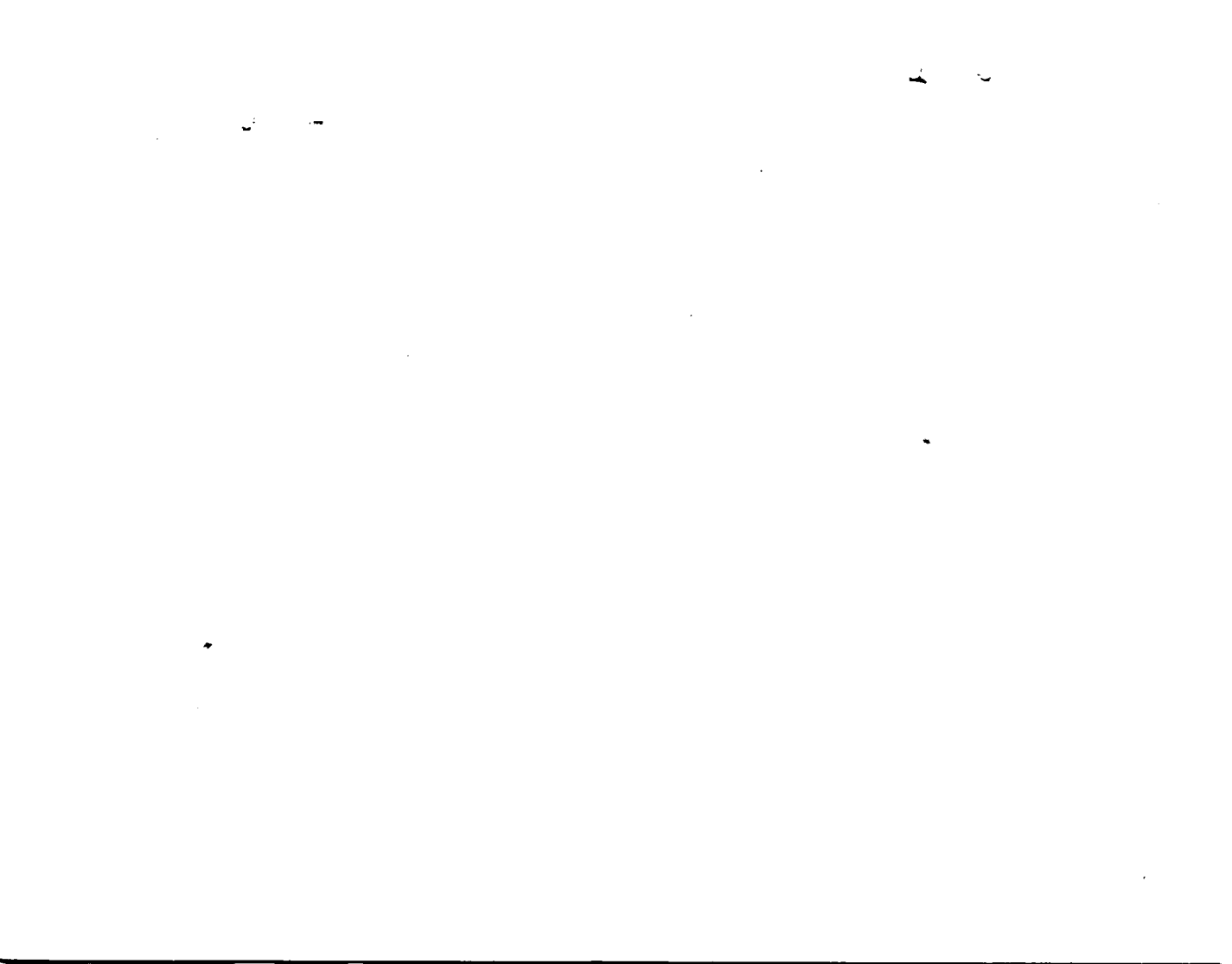
19 \_\_\_\_\_

Address \_\_\_\_\_

St. Maries

Filed \_\_\_\_\_

Sept. 1 1921H. E. Hunt



## 1. PLACE OF DEATH

County of Benedict Registration District No. 32  
 City of St. Maries Registration District No. 2049  
 (No. \_\_\_\_\_) (St. \_\_\_\_\_)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Joseph Vigue

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 35160Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white Single  
 (Write the word.)

## 6. DATE OF BIRTH

Aug 31 1921  
 (Month) (Day) (Year)

## 7. AGE

Still-born IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) St Maries Idaho

## 10. NAME OF FATHER

Fred Vigue

## 11. BIRTHPLACE OF FATHER

(State or Country) Wisconsin

## 12. MAIDEN NAME OF MOTHER

May Slavick

## 13. BIRTHPLACE OF MOTHER

(State or Country) Michigan

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Fred Vigue  
 (Address) St Maries Ida.

## 15.

Filed Sept 1 1921 H. E. Hunt  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Aug 31 1921  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Aug 31 1921, to Aug 31 1921  
 that I last saw him live on Aug 31 1921

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) A. D. Platt M. D.

Aug 31 1921 (Address) St Maries Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woodlawn Cem. 9-1 1921

## 20. UNDERTAKER ADDRESS

Mitchell Manager St Maries

- 9 -

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

189-1

249-223-006-696

## PLACE OF BIRTH

County of Bingham  
Hatched Fort Hall  
City of \_\_\_\_\_

## STATE OF IDAHO

Form V. S. No. 11-C-10m-9-7-11

Bureau of Vital Statistics

## CERTIFICATE OF BIRTH

S 93404

No. \_\_\_\_\_, \_\_\_\_\_ St.

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2194Registered No. 292

FULL NAME OF CHILD

Elizabeth Burdick

Sex of Child

FemaleTwin,  
Triplet  
or other?

\_\_\_\_\_ and \_\_\_\_\_

Number  
in order  
of birth

\_\_\_\_\_

Legiti-  
mate?YesDate of  
birthAug 231921

(Month)

(Day) (Year)

(To be answered only in event of plural births)

FULL  
NAMERowland Hazard Burdick

FATHER

FULL  
MAIDEN  
NAMEAlma May Frost

MOTHER

RESIDENCE

Fort Hall, Idaho

RESIDENCE

Fort Hall, Idaho

COLOR

WhiteAGE AT LAST  
BIRTHDAY43

(Years)

COLOR

WhiteAGE AT LAST  
BIRTHDAY10

(Years)

BIRTHPLACE

Providence R.I.

BIRTHPLACE

Dodge City, Kansas

OCCUPATION

Civil Engineer

OCCUPATION

WifeNumber of child of this mother, including present birth. 5Number of children, of this mother, now living, including present birth. 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

born deadat 10<sup>15</sup> a. M.

(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Henry R. WheelerPhysician  
(Physician or Midwife)

Given names added from a supplemental report

Address

Fort Hall, Idaho

Filed

Sept 8 1921 Mrs Helen E. Pattee

Registrar

OFFICE OF ATTENDING

MAN OF

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

RECEIVED  
SEP 15 1921

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 721  
County of Bingham Registration District No. 2194  
City of Fort Hall, Idaho (No. \_\_\_\_\_ St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 35171

Registered No. 117

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Burdick

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Single  
(Write the word.)

6. DATE OF BIRTH

Aug 23 1921  
(Month) (Day) (Year)

7. AGE

0 yrs. 0 mos. 0 ds.

IF LESS than 1 day  
how many ..... hrs. or  
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Fort Hall, Idaho

10. NAME OF FATHER

Rowland Hazard Burdick

11. BIRTHPLACE OF FATHER

(State or Country)

Providence, R. I.

12. MAIDEN NAME OF MOTHER

Alma May Frost

13. BIRTHPLACE OF MOTHER

(State or Country)

Lodge City, Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. Burdick  
Fort Hall, Idaho

15.

Filed

Aug 27 1921  
Mrs Helen E. Patne  
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 23 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 23 1921, to Aug 23 1921.  
that I last saw him alive on 1921

and that death occurred on the date stated above, at 11:15 A. M.

The CAUSE OF DEATH\* was as follows: At term, Stillborn due to anemia of mother from illness and operation for growth in mammary gland  
(Duration) ..... yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) Henry A. Wheeler M. D.

Aug 23 1921 (Address) Fort Hall, Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death ..... yrs. .... mos. .... ds. State ..... yrs. .... mos. .... ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Episcopal Mission Ft. Hall Aug 23 1921

20. UNDERTAKER

ADDRESS

W. J. Walker Pocatello, Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

813 - 211-006 - 813

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 93416

County of Bingham

City of Blackfoot

Registration District No. 121

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2194 Registered No. 304

Hospital \_\_\_\_\_

FULL NAME OF CHILD Muhammad Hall

Sex of Child <u>Male</u>	Twins or Triplets? <u>No</u>	and { } Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>Aug 11 1921</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

FULL NAME FATHER Silas Hall

FULL MAIDEN NAME MOTHER Mabel Hall

RESIDENCE Fort Hall Reservation

RESIDENCE Do

COLOR W AGE AT LAST BIRTHDAY 41 (Years)

COLOR W AGE AT LAST BIRTHDAY 18 (Years)

BIRTHPLACE Ky

BIRTHPLACE Ky

OCCUPATION Farmer

OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

Ed. Shotton, Jr. M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. E. Patrice M. D.

Given names added from a supplemental report.

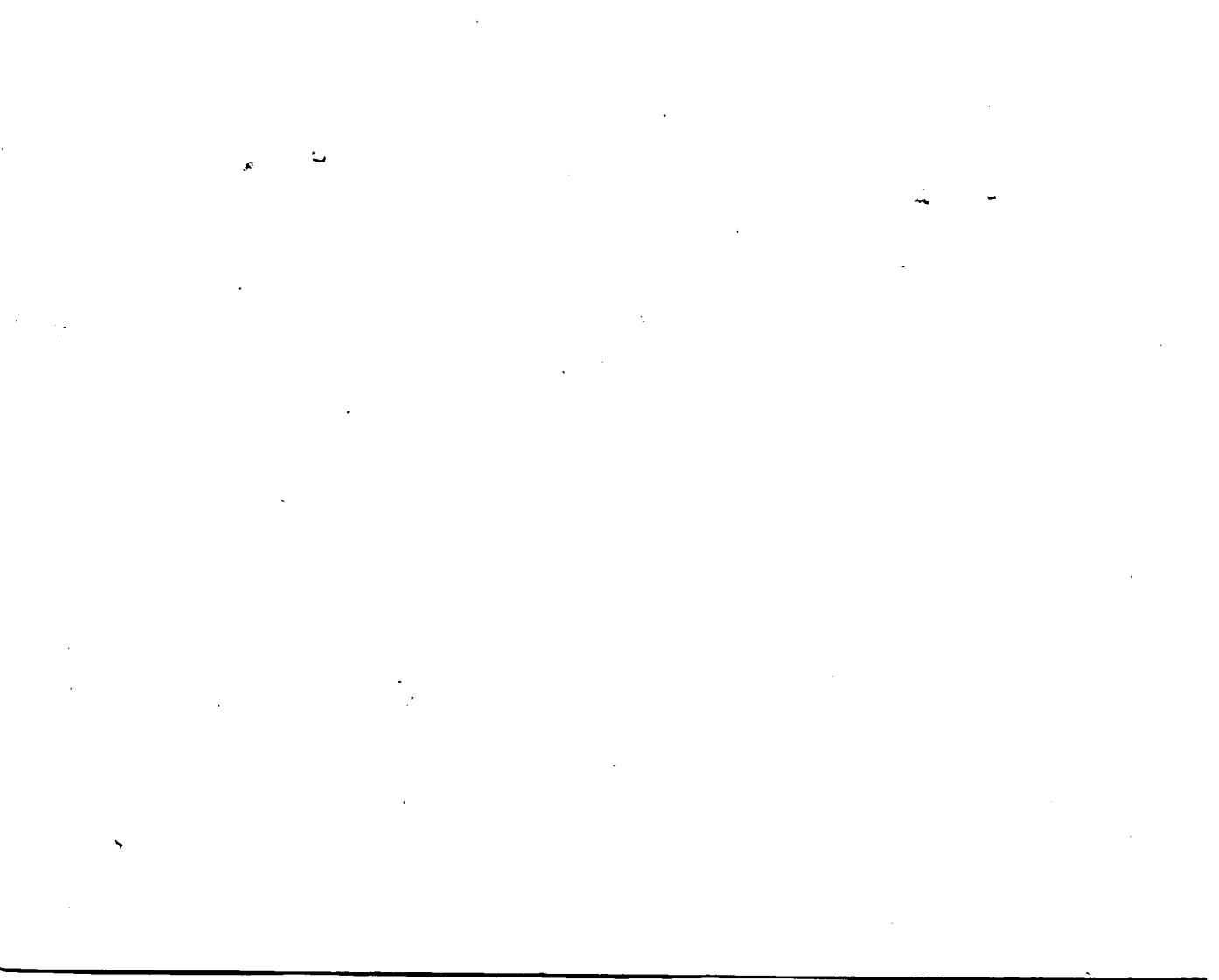
(Physician or midwife)

Address Blackfoot Idaho

Filed Sept 8 1921 Wm. H. E. Patrice

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

## 1. PLACE OF DEATH

County of Bingham Registration District No. 121  
City of Fork Wall Principal Registration District No. 2194 St. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Mrs. Mabel Hall

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 35168Registered No. 113

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED 5

(Write the word.)

6. DATE OF BIRTH

Aug 11<sup>th</sup> 1921  
(Month) (Day) (Year)

7. AGE

Stillborn  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Bingham Co Ida

10. NAME OF FATHER

Edna Hall

11. BIRTHPLACE OF FATHER

(State or Country)

Ky

12. MAIDEN NAME OF MOTHER

Mabel Hall

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Silas Hall  
21 Hall St. Idaho

15.

Filed

Aug 2 1921

Mrs. Helen E. Patrick  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 11 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

death 1921 to 1921

that I ~~last saw him~~ alive on 1921

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

Aug 21 1921 (Address) Blairstown, Pa.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moreland Ida

Aug 19 21

20. UNDERTAKER

ADDRESS

Silas Hall

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

212-209-007-859

## PLACE OF BIRTH

County of BlaineCity of Hailey

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

## FULL NAME OF CHILD

No Name Baby SisianSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-1-1-13

## CERTIFICATE OF BIRTH

S93425

File No. \_\_\_\_\_

Primary Registration District No. 2022 Registered No. 56

Sex of Child <u>Female</u>	Twin, Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>Yes</u>	Date of Birth <u>9</u> <u>9</u> <u>1921</u> (Month) (Day) (Year)
----------------------------	--	------------------------	---

FATHER  
FULL NAME Joseph W. SisianRESIDENCE Belleve, IdahoCOLOR White AGE AT LAST BIRTHDAY 42  
(Years)BIRTHPLACE Salt Lake County, UtahOCCUPATION FarmerMOTHER  
FULL MAIDEN NAME Ruth HestRESIDENCE Belleve, IdahoCOLOR White AGE AT LAST BIRTHDAY 32  
(Years)BIRTHPLACE OregonOCCUPATION House wifeNumber of child of this mother, including present birth, ..... 7 ..... Number of children of this mother now living, including present birth, ..... 4 .....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was ..... Still born ..... at ..... 8 P. M. .....  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

Physician .....  
(Physician or midwife)

Given names added from a supplemental report.

Address Hailey, IdahoFiled 10-6 1921 Robert H. Wright  
Registrar



**STATE OF IDAHO**  
**DEPARTMENT OF PUBLIC WELFARE**

Boise, Idaho,.....October 27,.....1921

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

---

Place of Birth	City	Hailey	File Number	93425	
	Street	Main		Registration Dist. No.	
	County	Blaine			
Sex of Child		Female	Date of Birth		September 9, 1921
Father		Joseph M. Sisiann	Mother		Bertha Hurst
		Full Name			Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

I will call it baby, Sisiann  
.....  
Child's Name in Full

Joseph Millard Sisiann  
Signature of Father or Mother

4-10-50



FORM V. S. No. 3-25 M. 1-19.

RECEIVED

OCT 5 1921

BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BlaineCity of Hailey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No nameSisianState of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 35181Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDFemale WhiteSingle  
(Write the word.)

6. DATE OF BIRTH

Sept

(Month)

9

(Day)

1921

(Year)

7. AGE

Still bornIF LESS than 1 day  
how many hrs.  
or min.?

Yrs.

Mos.

ds.

8. OCCUPATION

(a) Trade, profession or  
particular kind of workNone(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)

9. BIRTHPLACE

(State or Country)

Hailey, Idaho

10. NAME OF

FATHER

Joseph W. Sisian

11. BIRTHPLACE

OF FATHER

(State or Country)

Utah

12. MAIDEN NAME

OF MOTHER

Ruth Herst

13. BIRTHPLACE

OF MOTHER

(State or Country)

Oreg on

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Bellevue, Idaho

15.

Filed

9-61921R. H. Wright

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept

(Month)

9

(Day)

1921

(Year)

17. I HEREBY CERTIFY, That I attended deceased from  
9/9/21 19 to 9/9/21 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Premature 7 mo. Exsanguinated  
from Placenta Previae

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. D.

9/9/21(Address) Hailey, Idaho\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death Yrs. mos. days In the State Yrs. mos. days

Where was disease contracted  
if not at place of death?Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

Bellevue, Idaho

DATE OF BURIAL

9/11 1921

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

799-113-009-235  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED

County of Bonner

City of Sandpoint, Ida.

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

SEP 15 1921

BUREAU OF VITAL STATISTICS

Registration District No. 78

Primary Registration District No. 2155

CERTIFICATE OF BIRTH

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

S93469

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Aug. 13</u> 19 <u>21</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 2

FATHER  
FULL NAME Knock S Grindeland  
RESIDENCE Sandpoint, Ida. Rural  
COLOR White AGE AT LAST BIRTHDAY 30 (Years)  
BIRTHPLACE Brant, S. D.  
OCCUPATION Rancher

MOTHER  
FULL MAIDEN NAME Gina Sletager  
RESIDENCE Sandpoint, Ida. Rural  
COLOR White AGE AT LAST BIRTHDAY 29 (Years)  
BIRTHPLACE Norman Co. Minn.  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 1:30 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

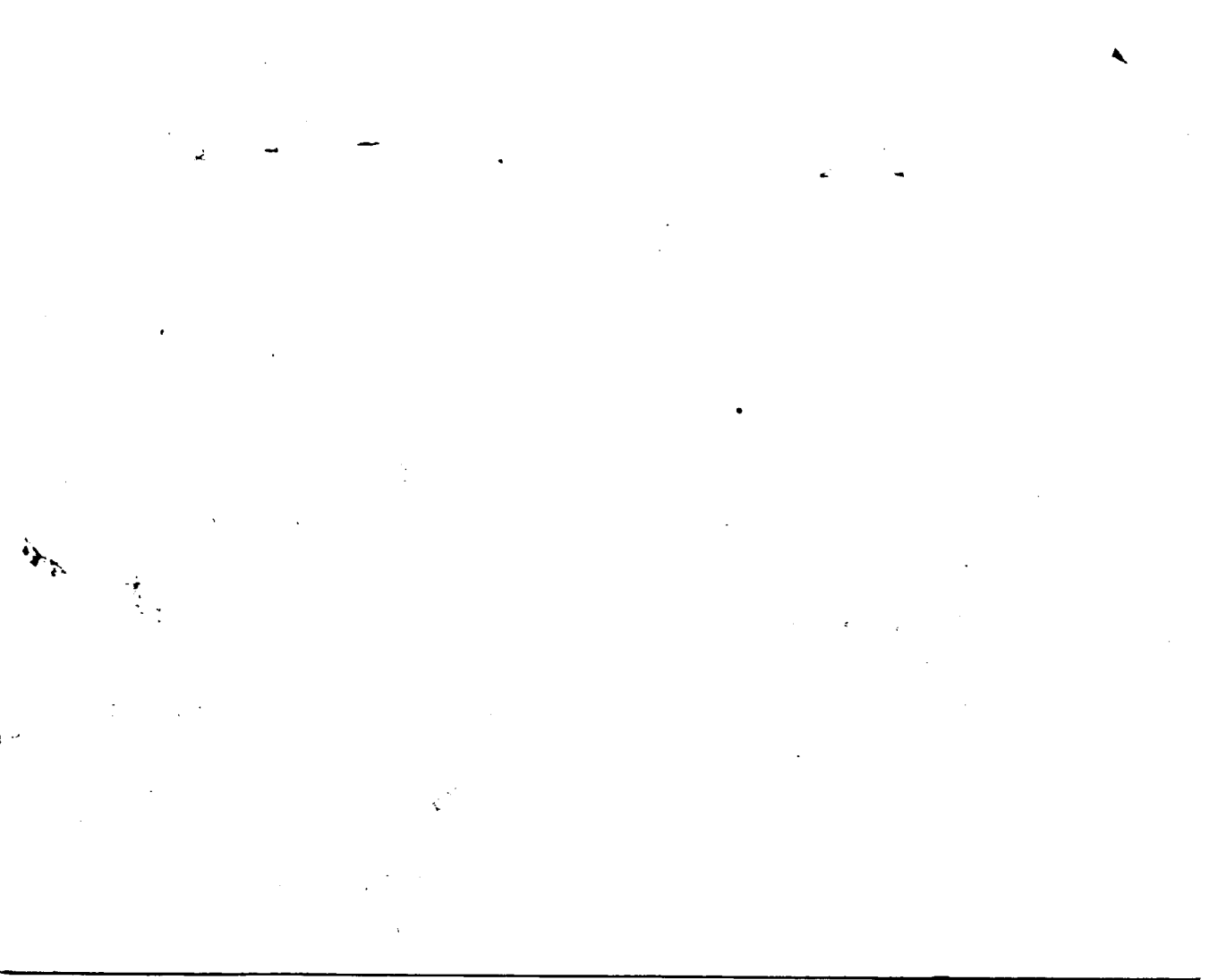
(Signature)

Floyd Wondle  
M.D.

(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_\_  
\_\_\_\_\_  
Registrar.

Address Sandpoint, Ida.  
Filed Sept 8 1921 Floyd Wondle  
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **35191**  
Registered No. ....  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH  
County of **Bonner**  
City of **Sandpoint**  
If death occurs away from usual residence, give facts called for under special information.  
2. FULL NAME **Stillborn**

RECEIVED  
Registration District No. **76**  
SEP 15 1921  
Primary Registration District No. **2155**  
BUREAU (No. ....) St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word.)  
6. DATE OF BIRTH **Aug 13 1921**  
(Month) (Day) (Year)  
7. AGE **IF LESS than 1 day**  
how many..... hrs.  
or..... min.?  
8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).  
9. BIRTHPLACE **Idaho**  
(State or Country)  
10. NAME OF FATHER **Enock S Grindeland**  
11. BIRTHPLACE OF FATHER **Brant, S. W.**  
(State or Country)  
12. MAIDEN NAME OF MOTHER **Lina Stetager**  
13. BIRTHPLACE OF MOTHER **Norman C. Munn**  
(State or Country)  
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) .....  
(Address) .....  
15. Filed **Sept 8 1921** **Floyd Grindeland**  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 12 1921**  
(Month) (Day) (Year)  
17. I HEREBY CERTIFY, That I attended deceased from **Sept 12 1921** to **Sept 12 1921**  
that I last saw him alive on **Sept 12 1921**  
and that death occurred on the date stated above, at **M.**  
The CAUSE OF DEATH was as follows: **anencephaly**  
(Duration) ..... Yrs. .... mos. .... ds.  
Contributory (Secondary) .....  
(Duration) ..... yrs. .... mos. .... ds.  
(Signed) **Floyd Grindeland** M. D.  
**Sept 12 1921** (Address) **Sandpoint, Idaho**  
\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.  
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death yrs. .... mos. .... days. In the State yrs. .... mos. .... days  
Where was disease contracted if not at place of death?  
Former or usual residence .....  
19. PLACE OF BURIAL OR REMOVAL **Max Mach. S. S. Grindeland** DATE OF BURIAL **Sept 12 1921**  
20. UNDERTAKER **E. S. Grindeland** ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

189-6

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

766 -103-012-352  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED  
SEP 22 1921

CERTIFICATE OF BIRTH

S 93484

County of Bonner

City of Laurel

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital Spencer

Registration District No. 7

File No. \_\_\_\_\_

Primary Registration District No. 2150

Registered No. 194

FULL NAME OF CHILD

James Earl Smith

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>No</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth... <u>Aug 3</u> 192 <u>1</u> (Month) (Day) (Year)
--------------------------	----------------------------------	-----------------------------------	------------------------	--

What bactericidal solution was used in eyes? 2% Argol

Number of child of this mother, including present birth. 11 Number of child of this mother now living, including present birth. 7

FATHER  
FULL NAME E. J. Gordon  
RESIDENCE Laurel Idaho  
COLOR White AGE AT LAST BIRTHDAY 40 (Years)  
BIRTHPLACE Utah  
OCCUPATION Engineering engineer

MOTHER  
FULL MAIDEN NAME Archie Leburn  
RESIDENCE Laurel Idaho  
COLOR White AGE AT LAST BIRTHDAY 40 (Years)  
BIRTHPLACE Utah  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 6:30 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Wm. J. Leburn

(Physician or midwife)

Give names added from a supplemental report.

Address

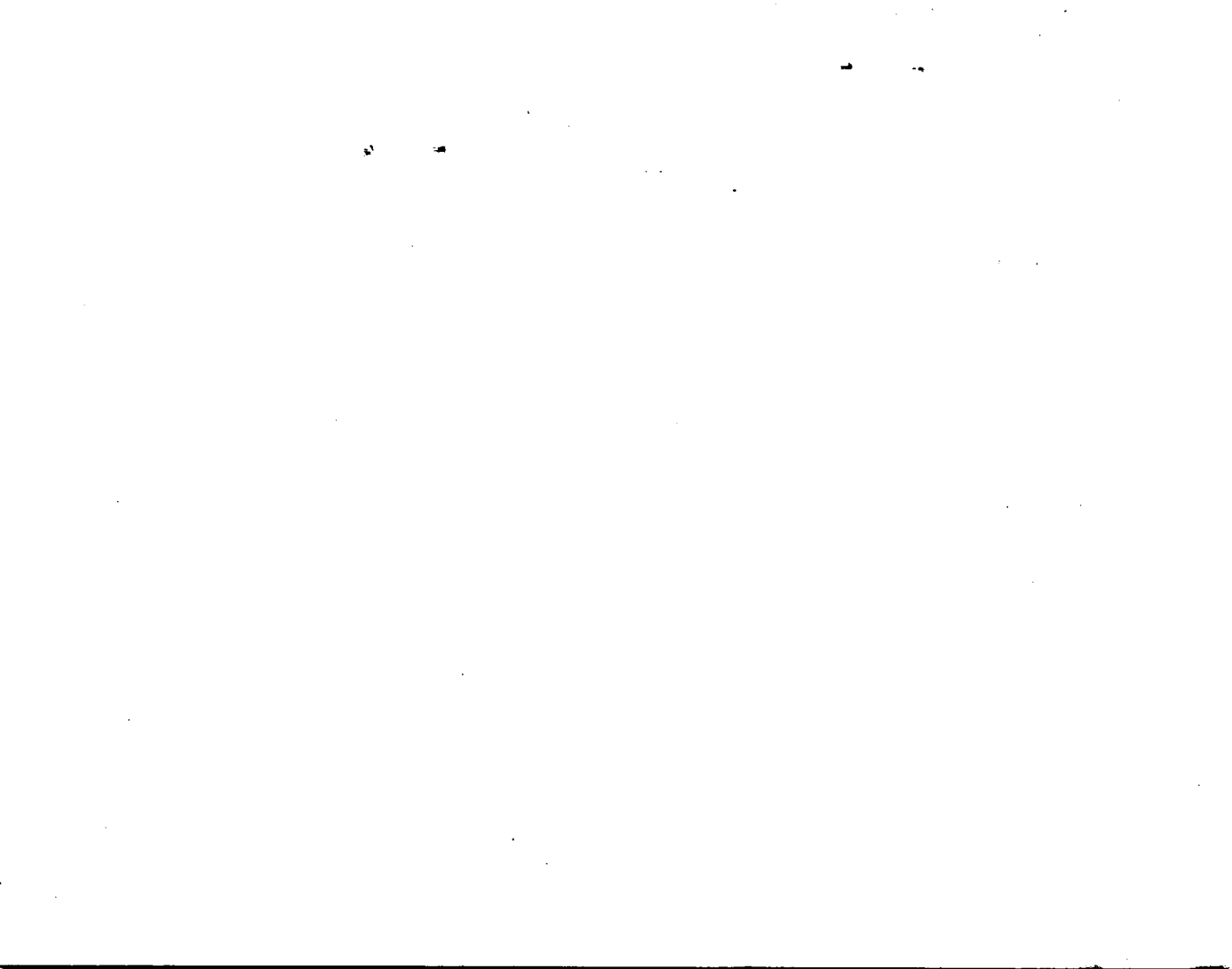
Laurel Idaho

Filed

Aug 6 1921

Registrar.

Registrar.





2. FULL NAME Asa Hunt John Wren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

### MEDICAL CERTIFICATE OF DEATH

6. DATE OF BIRTH

**16. DATE OF DEATH**

August 3 1921  
(Month) (Day) (Year)

7. AGE *born dead.* IF LESS than 1 day  
how many..... hrs.  
Yrs. Mos. ds. or..... min.?

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1921, to Aug 8 1921  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date stated above, at..... M

The CAUSE OF DEATH\* was as follows: Revelation detached from placenta

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

**Contributory.....**  
**(Secondary)**

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

(Signed) C. E. Hume M. D.

19. (Address) 1440 Foothills

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

**18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted  
if not at place of death?.....

Former or  
usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
San Jose, P.R.	Aug 4 1921

20. UNDERTAKER	ADDRESS
<p>1. <i>[Signature]</i></p> <p>2. <i>[Signature]</i></p> <p>3. <i>[Signature]</i></p> <p>4. <i>[Signature]</i></p> <p>5. <i>[Signature]</i></p> <p>6. <i>[Signature]</i></p> <p>7. <i>[Signature]</i></p> <p>8. <i>[Signature]</i></p> <p>9. <i>[Signature]</i></p> <p>10. <i>[Signature]</i></p> <p>11. <i>[Signature]</i></p> <p>12. <i>[Signature]</i></p> <p>13. <i>[Signature]</i></p> <p>14. <i>[Signature]</i></p> <p>15. <i>[Signature]</i></p> <p>16. <i>[Signature]</i></p> <p>17. <i>[Signature]</i></p> <p>18. <i>[Signature]</i></p> <p>19. <i>[Signature]</i></p> <p>20. <i>[Signature]</i></p>	<p>1. <i>[Signature]</i></p> <p>2. <i>[Signature]</i></p> <p>3. <i>[Signature]</i></p> <p>4. <i>[Signature]</i></p> <p>5. <i>[Signature]</i></p> <p>6. <i>[Signature]</i></p> <p>7. <i>[Signature]</i></p> <p>8. <i>[Signature]</i></p> <p>9. <i>[Signature]</i></p> <p>10. <i>[Signature]</i></p> <p>11. <i>[Signature]</i></p> <p>12. <i>[Signature]</i></p> <p>13. <i>[Signature]</i></p> <p>14. <i>[Signature]</i></p> <p>15. <i>[Signature]</i></p> <p>16. <i>[Signature]</i></p> <p>17. <i>[Signature]</i></p> <p>18. <i>[Signature]</i></p> <p>19. <i>[Signature]</i></p> <p>20. <i>[Signature]</i></p>

### 8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) *Idaho Falls Ida.*

10. NAME OF FATHER *Zeke Goodson*

11. BIRTHPLACE  
OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER *Arcia Labrada*

13. BIRTHPLACE  
OF MOTHER

(State or Country)

Utah

**14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) John F. [unclear]  
(Address) Idaho Falls, Ida

15. Sept 6 1921 W. F. ...  
Filed Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Mr. Lumsden, of

[illegible]

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

796-224-018-249

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of

RECEIVED

SEP 15 1921

CERTIFICATE OF BIRTH

City of

BUREAU OF VITAL  
STATISTICS  
Registration District No. 90

File No.

S 93637

No.

St.

Primary Registration District No. 2168

Registered No. 61

Hospital

FULL NAME OF CHILD

Mary Profit

Sex of  
Child

Girl

Twin  
Triplet  
or other

X

and Number  
in order  
of birth

X

Legiti  
mate?

Yes

Date of  
Birth

Aug 24

19 21  
(Month) (Day) (Year)FULL  
NAMEFATHER  
Howard E Profit

RESIDENCE

Chsahba

COLOR

White

AGE AT LAST  
BIRTHDAY35  
(Years)

BIRTHPLACE

Kentucky

OCCUPATION

Labour

FULL  
MAIDEN  
NAMEMOTHER  
Margaret Suter

RESIDENCE

Chsahba Ida

COLOR

White

AGE AT LAST  
BIRTHDAY28  
(Years)

BIRTHPLACE

Housewife

OCCUPATION

Kentucky

Number of child of this mother, including present birth 6

Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.at 12 P M.  
(Born alive or stillborn) 6mo\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

E. W. Howard  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Chsahba Ida

Filed

Apr 8 1921

J. M. Daily  
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

356-220-021-319  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S93693

County of Franklin RECEIVED  
City of Preston SEP 15 1921

CERTIFICATE OF BIRTH

No. 2119 St. 2119 File No. 122  
Hospital 27 Primary Registration District No. 27 Registered No. 122

FULL NAME OF CHILD Hill Born

(Certificate of no value without full name of child.)

Sex of Child female Twin Triplet or other? no and Number in order of birth 1 Legitimate? yes Date of birth Aug 20 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? 2.0% Argiro

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 4

FATHER  
FULL NAME Francis H Lewis  
RESIDENCE Preston  
COLOR W AGE AT LAST BIRTHDAY 35  
(Years)  
BIRTHPLACE Richmond, Utah  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Alma Carbridge  
RESIDENCE Preston  
COLOR W AGE AT LAST BIRTHDAY 34  
(Years)  
BIRTHPLACE Preston  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Born alive at 8:30 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

....., 19.....

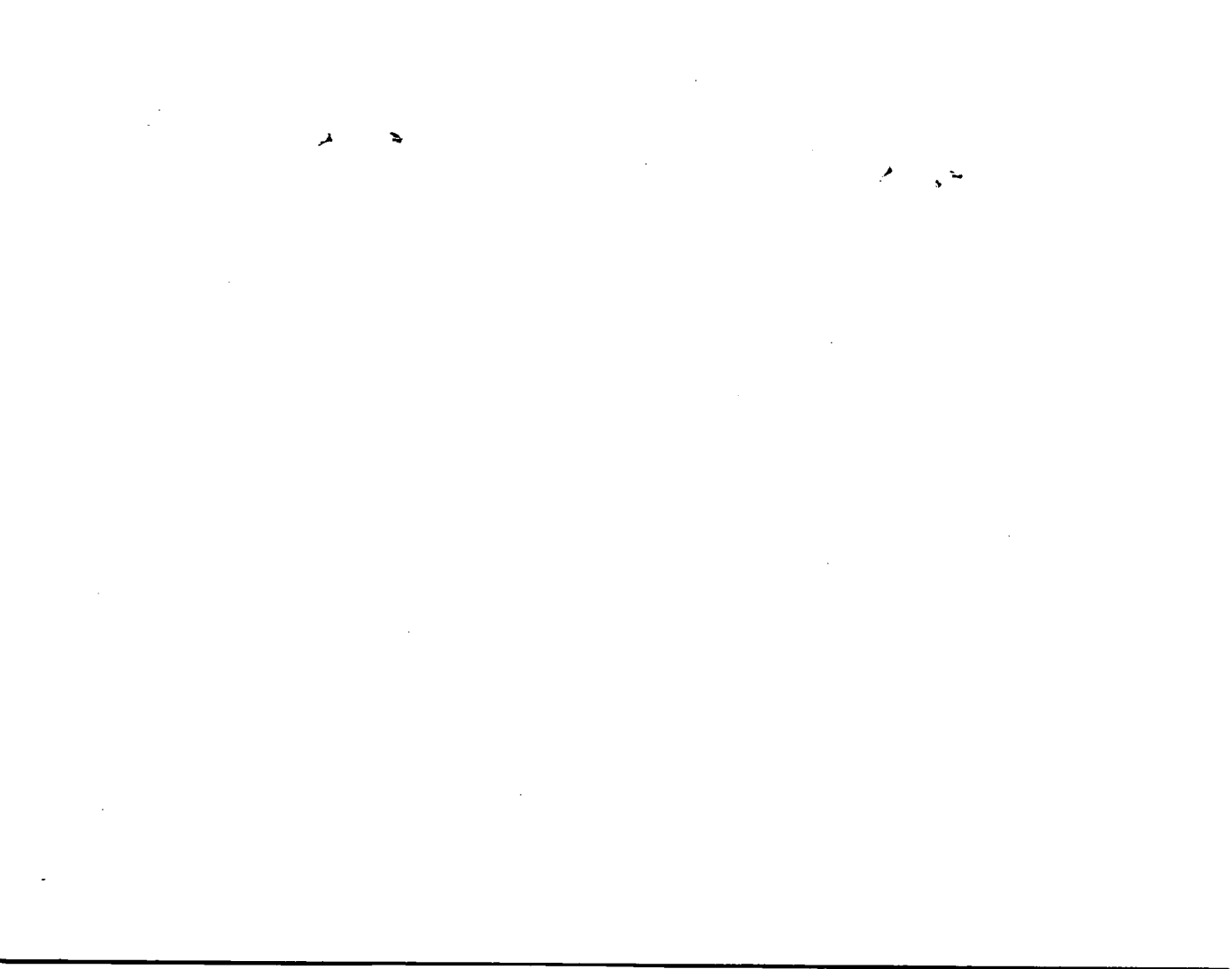
(Signature) Allen R. Carter

Address Preston, Idaho

Filed Sept 6 1921

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

RECEIVED  
SEP 13 1921  
JUL 10 1921  
STATISTICS

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Franklin Registration District No. \_\_\_\_\_  
City of Preston (No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

State LionState of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 35264

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
(Write the word.)

## 6. DATE OF BIRTH

Aug 20 1921  
(Month) (Day) (Year)

## 7. AGE

✓ Yrs. ✓ Mos. ✓ ds.IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work. ✓  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) Preston Idaho

## 10. NAME OF FATHER

Francis H. Lewis

## 11. BIRTHPLACE OF FATHER

(State or Country) Utah

## 12. MAIDEN NAME OF MOTHER

Oline Carbridge

## 13. BIRTHPLACE OF MOTHER

(State or Country) Preston Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Francis H. Lewis(Address) Preston Idaho

## 15.

Filed \_\_\_\_\_ 19 \_\_\_\_\_

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Aug 20 1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1921, to Aug 20 1921, that I last saw him not living alive on Aug 20 1921, and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH\* was as follows:

Not Known.  
There was much degeneration of placenta.

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Allen C. Cullen M. D.19 \_\_\_\_\_ (Address) Preston Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Dr. Cullen Preston  
20. UNDERTAKERAug 20 1921  
ADDRESS ✓

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

189-1



N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

999-209-022-845

PLACE OF BIRTH

County of Fremont

City of Ashton

No. 51

Hospital

FULL NAME OF CHILD

(Stillborn) (Reinhold)

93713

RECEIVED  
SEP 15 1941  
BUREAU OF VITAL  
STATISTICS

Registration District No. 1

File No.

Primary Registration District No. 6

Registered No. 81

Sex of Child

Female

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legitimate?

Yes

Date of Birth

8-9-1941  
(Month) (Day) (Year)

FULL NAME

Henry Reinhold

RESIDENCE

Ashton, Ida

COLOR

White

AGE AT LAST BIRTHDAY

27  
(Years)

BIRTHPLACE

Germany

OCCUPATION

Farmer

FULL MAIDEN NAME

Barbara Reinhold

RESIDENCE

Ashton, Ida

COLOR

White

AGE AT LAST BIRTHDAY

21  
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Housewife

Number of child of this mother, including present birth

1

Number of children of this mother now living, including present birth

0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

born alive

(Born alive or stillborn)

at 12:00 M

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

[Signature]

(Physician or midwife)

Given names added from a supplemental report.

Address

Ashton, Idaho

Filed

8-9-41

[Signature]

Registrar



[The remainder of the page contains extremely faint, illegible text, likely due to poor scan quality or intentional redaction. No specific words or phrases can be discerned.]

35268

FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Fremont*City of *Ashton*Registration District No. *103*Primary Registration District No. *6*File No. *2*Registered No. *2*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Steel Burn*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Female*

## 4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

*Aug**9**1921*

(Month)

(Day)

(Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

*Ashton Idaho*

## 10. NAME OF FATHER

*Henry Reinhardt*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Germany*

## 12. MAIDEN NAME OF MOTHER

*Lavon Hartman*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Frank Hardy*

(Address)

*Ashton Idaho*

## 15.

Filed

*8-9-21**C. M. Jackson*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*8*

(Month)

*9*

(Day)

*21*

(Year)

## 17. I HEREBY CERTIFY That I attended deceased from

19 to 19

that I saw alive at 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*SK*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*C. M. Jackson* M. D.  
*8-9-21* (Address) *Ashton Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Logan View Cemetery* *8-10-21*

## 20. UNDERTAKER

*James Keen*

ADDRESS

*Ashton Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably such*, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

189-6

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

212-109-026-619  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED

SEP 22 1921

CERTIFICATE OF BIRTH

S 93782

County of Jefferson

City of Menan

BUREAU OF VITAL

STATISTICS

Registration District No. 98

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2176

Registered No. 157

Hospital \_\_\_\_\_

FULL NAME OF CHILD

George Sakoto

Sex of Child

m

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and { Number  
in order  
of birth

Legiti-  
mate?

yes

Date of  
Birth

Apr 9 1921  
(Month) (Day) (Year)

FULL  
NAME

S. Sakoto

FATHER

FULL  
MAIDEN  
NAME

Kias Farnsawa

MOTHER

RESIDENCE

Menan

RESIDENCE

Menan

COLOR

Yellow

AGE AT LAST  
BIRTHDAY

41  
(Years)

COLOR

Yellow

AGE AT LAST  
BIRTHDAY

29  
(Years)

BIRTHPLACE

Japan

BIRTHPLACE

Japan

OCCUPATION

Farmer

OCCUPATION

Housewife

Number of child of this mother, including present birth 1

Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn on the date above stated.

at 10 P. M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Chas S Moody

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Menan

Filed

9/10

19

21

Ray H Fisher

Registrar.

Registrar.

23335

STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
CHICAGO, ILLINOIS

County of Cook  
City of Chicago  
No. 10  
Primer Registration District No. 10  
Residence No. 10  
Full Name of Child

Child	Full Name	Residence	Birthplace	Color	Age at last birthday
Mother	Full Name	Residence	Birthplace	Color	Age at last birthday
Occupation					

Number of child of this mother, including present birth \_\_\_\_\_

Number of children of this mother now living \_\_\_\_\_

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_

(Name and title of physician or midwife)

(Signature)

Given names of child \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

THIS CERTIFICATE WITH accompanying fee, is a REQUISITE FOR RECORDING IN THE OFFICE OF THE REGISTRAR OF VITAL STATISTICS, CHICAGO, ILLINOIS.

# STATE OF IDAHO

IC WELFARE

RECEIVED  
NOV 17 1921  
DEPARTMENT  
BUREAU OF VITAL  
STATISTICS

.....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City Moran  
Street .....  
County Jefferson  
Sex of Child Male  
Father S. Sakata Full Name

File Number 93782  
Registration Dist. No. 42  
Date of Birth April 8 1921  
Mother Kimio Furusawa Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

George Sakata  
Child's Name in Full

S. Sakata  
Signature of Father or Mother

MAR 16-1942



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

SEP 22 1921

Registration District No.

Primary Registration District No.

(No. Statistics)

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

(Duration) ..... Yrs..... mos..... ds.

Contributory  
(Secondary)

(Duration) ..... yrs..... mos..... ds.

(Signed)..... M. D.

19..... (Address).....

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1896

219-218-026-389  
PLACE OF BIRTH

Form V. S. No. 11-20m-7-26-19

RECEIVED STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
SEP 22 1921  
BUREAU OF VITAL STATISTICS  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

County of Jefferson

City of Lewisville

Registration District No. 98

File No. 93810

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2176 Registered No. 179

Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>7</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>7-18-21</u> (Month) (Day) (Year)
-----------------------	---	-----	--------------------------------	---------------------------	---

FULL NAME FATHER  
Ralph Barney

RESIDENCE Lewisville

COLOR W AGE AT LAST BIRTHDAY 24  
(Years)

BIRTHPLACE Utah

OCCUPATION Farmer

FULL MAIDEN NAME MOTHER  
Elsie Christensen

RESIDENCE same

COLOR W AGE AT LAST BIRTHDAY 23  
(Years)

BIRTHPLACE Utah

OCCUPATION Housewife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 9 45 a M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Ray H Fisher

(Physician or midwife)

Given names added from a supplemental report.

Address Ruby

Filed 9/10/21 19 Ray H Fisher

Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

STATISTICS  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK

01860

Noted: yel

Primary Registration District No.

## Testimony

CHILD TO BEAR LUP

(add'l lang to serve at vno housewars of all)

**WOMEN**

১১৫৯

## RESULTS

1144

1954年12月

SECRET

TRAJ 133DA  
YAOH131B

**COLON**

YACHTING

04-02

SDA/9HT(10)

**BLITZKAMP**

WDIA 90530

**WICK APU 000**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE,

and now John will be able to become a full time student.

( 94174174 )

to make the payments on my credit card.  
I have been told that I must pay  
at least \$100 a month. I am not  
sure if this is true or not.

① 1950 年 1 月 1 日 以前 出生 者 均 属 1950 年 1 月 1 日 以前 出生 者

**Copyright Clearance Center**

bold:

7-10-52

**MAKING RESERVES FOR BINDING**  
**RECORDS TO BE KEPT IN A BINDER**—THE COMMISSIONERS OF THE GENERAL LAND OFFICE, LONDON, HAVE ISSUED A CIRCULAR ADVISING THE RECORDS OF THE LAND OFFICE TO BE KEPT IN A BINDER. THE CIRCULAR STATES THAT THE RECORDS OF THE LAND OFFICE SHOULD BE KEPT IN A BINDER, AND THAT THE BINDER SHOULD BE KEPT IN A SAFE. THE CIRCULAR ALSO STATES THAT THE BINDER SHOULD BE KEPT IN A SAFE, AND THAT THE BINDER SHOULD BE KEPT IN A SAFE.

## RECEIVED CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson District No. 98  
City of Lewisville Registrar's Office District No. 2176  
St.)File No. 35287  
Registered No. 31If death occurs away from  
usual residence, give facts  
called for under special in-  
formation.

2. FULL NAME

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED infant  
(Write the word.)

6. DATE OF BIRTH

7 - 18 92  
(Month) (Day) (Year)

7. AGE

stillborn  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or  
particular kind of work  
(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF  
FATHERRalph Barney11. BIRTHPLACE  
OF FATHER

(State or Country)

Utah12. MAIDEN NAME  
OF MOTHERElsie Christensen13. BIRTHPLACE  
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ralph Barney

(Address)

Lewisville

15.

Filed

9/10/21 Roy H. Fisher  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 - 18 21  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw h..... alive on 19

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)..... M. D.

19 (Address).....\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)At place In the  
of death yrs. mos. days. State yrs. mos. daysWhere was disease contracted  
if not at place of death?Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewisville7/17/19

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

189-16

391-107-029-395

Form V. S. No. 11-C-25m-7-21-22

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of

City of

No.

St.

Hospital

FULL NAME OF CHILD

Primary Registration District No.

File No.

Sex of Child

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

(To be answered only in event of plural births)

Legiti  
mate?

Date of Birth

(Month)

(Day)

(Year)

FULL NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL MAIDEN NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

Number of child of this mother, including present birth. / Number of children of this mother now living, including present birth. 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 119 N. on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

Address

Filed

19

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

INVESTMENT REVEALED FOR BINDING

FULL NAME OF CHILD <i>John E. Brown</i>		SEX OF CHILD <i>M</i>	
BIRTHPLACE <i>St. Louis, Mo.</i>		COLOR <i>W</i>	
BIRTHDAY <i>12-17-1917</i>		AGE AT LAST BIRTHDAY <i>25</i>	
OCCUPATION <i>Student</i>		BIRTHPLACE <i>St. Louis, Mo.</i>	
OCCUPATION <i>Student</i>		BIRTHDAY <i>12-17-1917</i>	
RESIDENCE <i>St. Louis, Mo.</i>		COLOR <i>W</i>	
NAME AND ADDRESS OF PERSON TO WHOM THIS CARD IS TO BE SENT <i>John E. Brown, St. Louis, Mo.</i>		NAME OF CHILD OF THIS HOUSEHOLD <i>John E. Brown</i>	
SIGNATURE OF ATTENDING PHYSICIAN <i>[Signature]</i>		SIGNATURE OF CHILD <i>[Signature]</i>	
DATE OF EXAMINATION <i>12-17-1917</i>		DATE OF BIRTH <i>12-17-1917</i>	



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

SEP 15 1921 CERTIFICATE OF DEATH

35302

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Registration District No.

Primary Registration District No.

(No.)

(St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

## 6. DATE OF BIRTH

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

19

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19  
that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillborn - been dead about 3 wks. Cause unknown

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

19

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

213-118-031-213

PLACE OF BIRTH

RECEIVED  
OCT 3 1921

BUREAU OF VITAL STATISTICS

OF IDAHO  
ITAL STATISTICS

Form V. S. No. 11-C-25m-9-8-15

County of LewinCity of NopperNo. Village St.Registration District No. 47

Primary Registration District No.

CERTIFICATE OF BIRTH

File No.

S 93881

Registered No.

153

Hospital

FULL NAME OF CHILD

Back

Sex of Child

Male

Twin  
Triplet  
or other?  
(To be answered only in event of plural births){ and { Number  
in order  
of birth

2

Legiti-  
mate?

Yes

Date of Birth

8-18

(Month)

(Day)

1921

FULL NAME

FATHER  
John Back. (Edward)

FULL MAIDEN NAME

MOTHER  
Myrtle Sather

RESIDENCE

Nopper

RESIDENCE

Nopper

COLOR

White

AGE AT LAST BIRTHDAY

27

(Years)

COLOR

White

AGE AT LAST BIRTHDAY

22

(Years)

BIRTHPLACE

Oregon

BIRTHPLACE

Idaho

OCCUPATION

Laborer

OCCUPATION

Housewife

Number of child of this mother, including present birth

2

Number of children of this mother now living, including present birth

2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE \*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.Stillborn  
(Born alive or stillborn)

at 7 P. M.

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. Taylor M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address

Nopper

Idaho

Filed

9-29-21

Albert Huff



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12-11 M. 7-24-11

RECEIVED

OCT 8 1921

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis  
City of Neperce

District No. 47  
Primary Registration District No. \_\_\_\_\_  
(No. \_\_\_\_\_, St.)

File No. 35314  
Registered No. 68

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wesley Irwin Back

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant  
(Write the word.)

6. DATE OF BIRTH

Aug 18 1921  
(Month) (Day) (Year)

7. AGE

Infant

IF LESS than 1 day  
how many \_\_\_\_\_ hrs. or  
\_\_\_\_\_ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Neperce Idaho

10. NAME OF FATHER

John Edward Back

11. BIRTHPLACE OF FATHER

(State or Country)

Portland Oregon

12. MAIDEN NAME OF MOTHER

Mirtle Marian Sather

13. BIRTHPLACE OF MOTHER

(State or Country)

Neperce Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mirtle M. Back  
Neperce, Idaho

15.

Filed 8-27-1921

Albert Huff  
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 18 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 18 1911, to Aug 18 1911

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 1911

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. F. Caylor M. D.

19 \_\_\_\_\_ (Address) Neperce Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, \_\_\_\_\_  
If not at place of death? \_\_\_\_\_

Former or \_\_\_\_\_  
usual residence. \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

At Neperce Cemetery

8-18-1921

20. UNDERTAKER

ADDRESS

Albert Huff

Neperce Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

189-6  
**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term, on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

619-211-031-793

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTHCounty of Lincoln

RECEIVED

SEP 15 1921

City of KamiahBUREAU OF VITAL  
STATISTICSRegistration District No. 49File No. S 93883

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2478

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Baby KarenSex of  
Child FemaleTwin  
Triplet  
or other?  
(To be answered only in event of plural births)

and

Number  
in order  
of birthLegiti  
mate?Date of  
BirthAug. 11 1921  
(Month) (Day) (Year)FULL  
NAME

FATHER

W. H. KarenFULL  
MAIDEN  
NAME

MOTHER

Lotha Sitter

RESIDENCE

Kamiah

RESIDENCE

Kamiah

COLOR

whiteAGE AT LAST  
BIRTHDAY43  
(Years)

COLOR

whiteAGE AT LAST  
BIRTHDAY40  
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Barber

OCCUPATION

ShampooerNumber of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 5

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 8 G. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. Bryan M. D.

(Physician or midwife)

On name added from a supplemental report.

no. This baby 19

Address

Kamiah7 Mrs. Stillborn

Filed

8/11 1921

Registrar

C. J. G.

Registrar

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

FROM 70 FLORENCE

100-44392

\_\_\_\_\_

CONFIDENTIAL

**WORLD  
GIRL**

10-10-68

Continued on page 20

**THE**

(b)(7)(D)

1994

**Abstract**

**SECRET**

**SECRET**

NO. 100

86-103



**SECRET**

**WOLFGANG**

**DECEMBER 1968**

RECORD OF ATTENDING PHYSICIAN OR MIDWIFE

**(Continued)**

12/17/79

1995

**WVF**



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 25 M. 1-16-13

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH.

County of Idaho Registration District No. 47  
City of Kamiah Primary Registration District No. 428  
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Lorena

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 35316

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single  
(Write the word.)

## 6. DATE OF BIRTH.

Aug. 11 1921  
(Month) (Day) (Year)

7. AGE 11 months, 21 days If LESS than 1 day how many hrs. or min.  
Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country)

Kamiah Id.

## 10. NAME OF FATHER

Nate Foreman

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

Lottie Pihl

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Mrs. Nate Foreman  
Kamiah Idaho

## 15.

Filed

8/11/21

191

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Aug. 11 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11 to 11 1921, that I last saw him alive on 11 1921, and that death occurred on the date stated above, at \_\_\_\_\_ M. The CAUSE OF DEATH\* was as follows:

Scarlet fever

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. H. Bryan M. D.

4/11/1921 (Address) Kamiah

\*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

St. John's Kamiah Id.8/11 1921

## 20. UNDERTAKER

## ADDRESS

W. H. BryanKamiah

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

169-1

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

253-128-032-897  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Lincoln RECEIVED  
City of Shoshone SEP 15 1921  
No. 16 St. Bureau of Vital Statistics  
Hospital home Primary Registration District No. 1016 File No. S 93890  
Registered No. 3142  
FULL NAME OF CHILD Baby Belle  
(Certificate of no value without full name of child.)

Sex of Child M Twin other and (Number in order of birth) 3 Legitimate? yes Date of birth Aug 28 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?.....

Number of child of this mother, including present birth... 5 Number of children of this mother now living, including present birth... 2

FATHER  
FULL NAME Archie C. Bell  
RESIDENCE Shoshone, Ida  
COLOR white AGE AT LAST BIRTHDAY 31 (Years)  
BIRTHPLACE Nevada  
OCCUPATION R. A. Employee

MOTHER  
FULL MAIDEN NAME Lillian Higgins  
RESIDENCE Shoshone, Ida  
COLOR white AGE AT LAST BIRTHDAY 24 (Years)  
BIRTHPLACE Arkansas  
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 3:45 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) .....

(Physician or midwife)

Give names added from a supplemental report.

Address .....

File Apr 29 1921 J. L. Turner  
Registrar.



SECRET



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH Shoshone Registration District No. 16  
County of Lancaster Primary Registration District No. 1016  
City of Shoshone St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Bell

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 35319  
Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Aug. 28 1921  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many ..... hrs. or  
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Shoshone Id.

10. NAME OF FATHER

Archie C Bell

11. BIRTHPLACE OF FATHER

(State or Country) Nevada

12. MAIDEN NAME OF MOTHER

William Higginbottom

13. BIRTHPLACE OF MOTHER

(State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. F. Keller(Address) Jerome Id.

15.

Filed Aug 28 192121

J. L. Sullivan  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 28 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 28 1921, to Aug. 28 1921.

that I last saw him ..... alive on ..... 191.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

Still Born due to delivery  
engaged occipital posterior  
position, forceps delivery

(Duration) ..... Yrs. .... mos. .... ds.

Contributory

(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) Chas. F. Keller M. D.19..... (Address) Jerome Id.

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone  
None

August 28 1921

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

15-2-a

312-224-032-156

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of LincolnCity of Shoshone

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

## RECEIVED CERTIFICATE OF BIRTH

SEP 15 1921

Registration District No. 16

File No.

S 93891

STATISTICS

Primary Registration District No. 1016Registered No. 41FULL NAME OF CHILD Arline Casey

Sex of Child

FemaleTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate?Date of  
BirthAug 24  
(Month) (Day)19 21  
(Year)FULL  
NAMEFATHER  
Carl W. Casey

RESIDENCE

Shoshone Ida

COLOR

WhiteAGE AT LAST  
BIRTHDAY24  
(Years)

BIRTHPLACE

Washington

OCCUPATION

FarmingFULL  
MAIDEN  
NAMEMOTHER  
Helen L. Jefferson

RESIDENCE

Shoshone Ida

COLOR

WhiteAGE AT LAST  
BIRTHDAY22  
(Years)

BIRTHPLACE

New Jersey

OCCUPATION

HousewifeNumber of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 11:00 M.  
on the date above stated. (Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

J. H. Cromwell M. D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

August 25<sup>th</sup> 1921

Registrar

Registrar

STATISTICAL BUREAU  
DEPARTMENT OF COMMERCE  
BIRTH RECORD

23304

County of <u>Franklin</u>		City of <u>Franklin</u>	
Primary Registration District No. <u>1018</u>		St. <u>1018</u>	
Date of Birth <u>1918</u>		Sex of Child <u>Male</u>	
Full Name of Child <u>John A. [unclear]</u>		Number of Child in Family <u>1</u>	
Mother's Name <u>[unclear]</u>		Date of Birth <u>1918</u>	
Residence <u>[unclear]</u>		Color <u>White</u>	
Age at Last Birthday <u>24</u>		Birthplace <u>[unclear]</u>	
Occupation <u>[unclear]</u>		Occupation <u>[unclear]</u>	

CERTIFICATE OF ATTENDANCE

I hereby certify that I attended the birth of the child named above and that the child is now living.

Signature of Physician or Midwife: [Signature]

Date: 1918

PRINTED AND PUBLISHED BY THE BUREAU OF STATISTICS  
DEPARTMENT OF COMMERCE  
WASHINGTON, D. C.



## 1. PLACE OF DEATH

County of Latah  
City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Arline Casey

## CERTIFICATE OF DEATH

Registration District No. 16Primary Registration District No. 1016State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 35318Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Stillborn

## 6. DATE OF BIRTH

Aug 24 1921  
(Month) (Day) (Year)

## 7. AGE

Stillborn  
Yrs. Mos. ds.IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

## 9. BIRTHPLACE

(State or Country)

Shoshone, Ida.

## 10. NAME OF FATHER

Carl W. Casey

## 11. BIRTHPLACE OF FATHER

(State or Country)

Washington

## 12. MAIDEN NAME OF MOTHER

Helene L. Jefferson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

New Jersey

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

## 15.

Filed

Aug 25 1921

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Aug 24 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....  
that I last saw him alive on 19.....  
and that death occurred on the date stated above, at M.  
The CAUSE OF DEATH\* was as follows:Stillborn  
Gestation period 9 months  
(Duration) Yrs. mos. ds.Contributory  
(Secondary)(Duration) yrs. mos. ds.  
(Signed) J. H. Cromwell M. D.  
19..... (Address) Boziling, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Shoshone Aug 25 1921

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

189-6

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

993-123-034-265

Form V. S. No. 11-C--25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of Blaine

SEP 15 CERTIFICATE OF BIRTH

City of Paper

BUREAU OF VITAL  
Registration District No. 19

File No. **S 93933**

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2015 Registered No. 153

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? <u>No</u> (To be answered only in event of plural births)	and	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>8</u> <u>23</u> <u>1921</u> (Month) (Day) (Year)
--------------------------	---	-----	-----------------------------------	------------------------	--

FULL NAME FATHER Walter A Rice

FULL MAIDEN NAME MOTHER Jennie Sweet

RESIDENCE Paper, Blaine

RESIDENCE Paper, Blaine

COLOR White AGE AT LAST BIRTHDAY 23  
(Years)

COLOR White AGE AT LAST BIRTHDAY 30  
(Years)

BIRTHPLACE Idaho

BIRTHPLACE Idaho

OCCUPATION Laborer

OCCUPATION Housewife

Number of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at Paper, Blaine on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) B. L. Loomis

(Physician or midwife)

Given names added from a supplemental report.

Address Paper, Blaine

Filed Sept. 8 1921

Registrar

Registrar

4

962-217-042-363

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

SEP 15

BUREAU OF VITAL STATISTICS

County of Twin FallsBUREAU OF CERTIFICATE OF BIRTH  
STATISTCity of Twin FallsRegistration District No. 37

File No.

S 94066

No. \_\_\_\_\_ St.

Hospital CountyPrimary Registration District No. 9085

Registered No. \_\_\_\_\_

FULL NAME OF CHILD Baby Roberts

Sex of Child

FemaleTwin  
Triplet  
or other? 1

and

Number  
in order  
of birth 3Legiti  
mate? yesDate of  
Birth Aug 17

(Month)

(Day)

1921  
(Year)FULL  
NAMECharley Roberts

FATHER

RESIDENCE

Twin Falls Idaho

COLOR

WhiteAGE AT LAST  
BIRTHDAY40

(Years)

BIRTHPLACE

Indiana

OCCUPATION

Shoe & Metal WorkerFULL  
MAIDEN  
NAMEMarie Cotton

MOTHER

RESIDENCE

Twin Falls Idaho

COLOR

WhiteAGE AT LAST  
BIRTHDAY34

(Years)

BIRTHPLACE

Wyoming

OCCUPATION

HousewifeNumber of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_, at 2<sup>30</sup> P.M.  
on the date above stated.\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

John M. Pough  
Osteopathic Physician  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

Aug 27 1921

Registrar

Registrar

John M. Pough

Car

2

1000

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

693-103-042-751

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH  
County of Twin Falls  
City of Twin Falls  
No. 260 Eight Six East  
Hospital County  
FULL NAME OF CHILD Wilson

RECEIVED STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
SEP 15  
BUREAU OF  
STATISTICS  
Registration District No. 37 File No. S 94067  
Primary Registration District No. 1085 Registered No. \_\_\_\_\_

Sex of Child Male Twin Triplet or other? 1 and { Number in order of birth 5 } Legiti mate? yes Date of Birth Aug 3 1921  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER		MOTHER	
FULL NAME	<u>Edwin A. Wilson</u>	FULL MAIDEN NAME	<u>Lena Leary</u>
RESIDENCE	<u>Twin Falls</u>	RESIDENCE	<u>Twin Falls</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>36</u> (Years)	AGE AT LAST BIRTHDAY	<u>35</u> (Years)
BIRTHPLACE	<u>Ohio</u>	BIRTHPLACE	<u>Peru</u>
OCCUPATION	<u>Accountant</u>	OCCUPATION	<u>Housewife</u>

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_, at 2 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. R. Morgan, M.D.

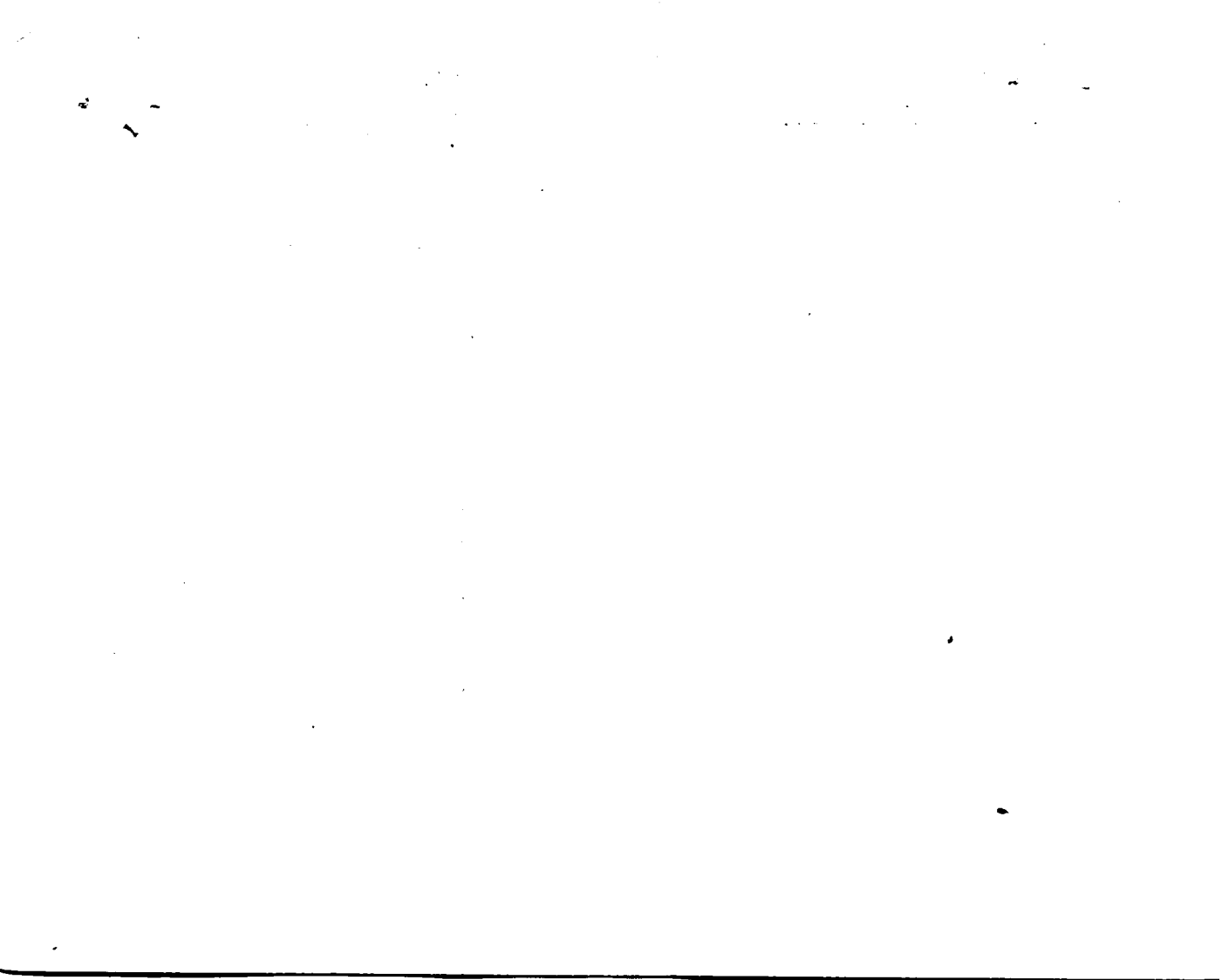
Given names added from a supplemental report.

19

(Physician or midwife)  
Address Twin Falls, Idaho

Filed Aug 19 1921 John G. Morgan Registrar

Registrar





## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 35374

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

County of *Franklin*

City of \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

RECEIVED  
SEP 15 1921  
BUREAU OF VITAL STATISTICSRegistration District No. *37*  
Primary Registration District No. *1085*  
(No. \_\_\_\_\_) (St. \_\_\_\_\_)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male white Infant* (Write the word.)

6. DATE OF BIRTH

*Aug 4 1921*  
(Month) (Day) (Year)

7. AGE

*0* Yrs. *0* Mos. *0* ds.IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)*Infant*

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*Edwin Wilson*

11. BIRTHPLACE OF FATHER

(State or Country)

*Ohio*

12. MAIDEN NAME OF MOTHER

*Lena Geary*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Penn*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Edwin Wilson*

(Address) \_\_\_\_\_

15. Filled

*Aug 5 1921**John B. Murphy*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Aug 4 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date stated above, at *3:00* P.M.

The CAUSE OF DEATH\* was as follows:

*Still birth*

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

*John B. Morgan*

M. D.

*8-4-1921*(Address) *Franklin Falls, Ida.*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Franklin Falls, Ida.**8-5-1921*

20. UNDERTAKER

ADDRESS

*J. E. Wright**Franklin Falls*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of Certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

189-6

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

261-129-001-342  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S94158

County of Ada RECEIVED  
City of Boise OCT 31 1921  
No. 409 Resequie St. BUREAU OF VITAL  
Hospital \_\_\_\_\_ Registration District No. 2  
Primary Registration District No. 1004

File No. \_\_\_\_\_  
Registered No. 458

FULL NAME OF CHILD

Robert Theodore Swartz  
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { } Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Oct. 29</u> , 192 <u>1</u> . (Month) (Day) (Year)
--------------------------	---	--	------------------------	---

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 1 Number of child of this mother now living, including present birth... 0

FATHER  
FULL NAME Clarence T. Swartz  
RESIDENCE 409 Resequie St., Boise, Idaho  
COLOR White AGE AT LAST BIRTHDAY 23 (Years)  
BIRTHPLACE Montana  
OCCUPATION Barber

MOTHER  
FULL MAIDEN NAME Pauline P. Cuse  
RESIDENCE 409 Resequie St., Boise, Idaho  
COLOR White AGE AT LAST BIRTHDAY 20 (Years)  
BIRTHPLACE Carolina  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 12:30 a. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

T. H. Braxton  
M.D.  
(Physician or midwife)

Give names added from a supplemental report.

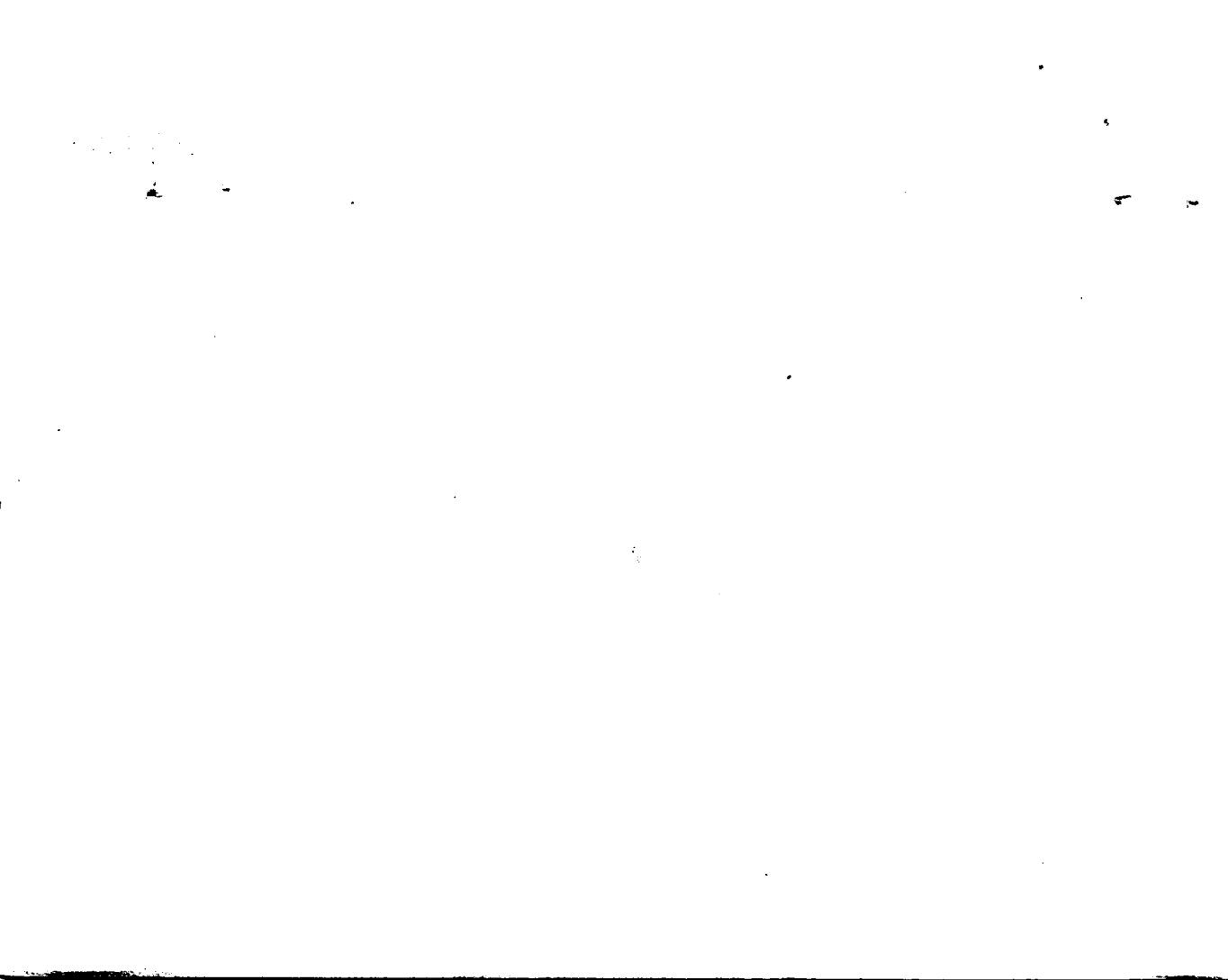
Address \_\_\_\_\_

Boise, Idaho

Filed 10/31 1921

R. L. Pratt  
Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

# CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada Registration District No. 2  
City of Boise Registration District No. 1001  
City of Boise St. Residence

File No. 35413  
Registered No. 312

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME

Robt. Theodore Swartz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

6. DATE OF BIRTH

Oct 28 - 1921  
(Month) (Day) (Year)

7. AGE

Still Born  
Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

None.

9. BIRTHPLACE

(State or Country)

Boise, Idaho

10. NAME OF FATHER

C. T. Swartz

11. BIRTHPLACE OF FATHER

(State or Country)

Mont

12. MAIDEN NAME OF MOTHER

Pauline Luse

13. BIRTHPLACE OF MOTHER

(State or Country)

Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. McBratney

(Address)

Boise, Idaho.

15.

Filed Oct 29 1921.

R. H. Pratt  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 29 - 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 29 1921 to Oct 29 1921

that I last saw him Still Born 19

and that death occurred on the date stated above, at 123.4th

The CAUSE OF DEATH\* was as follows:

Bruch Extraction

(Duration) Yrs. mos. ds.

Contributory (Secondary) Transpiration of Birth

(Duration) yrs. mos. ds.

(Signed) T. N. Bratton M. D.

Oct 29 1921 (Address) Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woods Hill Cemetery

DATE OF BURIAL

10/29/21

20. UNDERTAKER

W. McBratney

ADDRESS

Boise Idaho.

2  
4  
8  
1

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

259-202-004-874  
PLACE OF BIRTH

County of Blaine  
City of Montpelier  
No. (Wardboro) St.

RECEIVED  
OCT 31 1921  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
BUREAU OF VITAL STATISTICS

Registration District No. 52

CERTIFICATE OF BIRTH

S94292

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2136

Registered No. \_\_\_\_\_

FULL NAME OF CHILD Baby Burrey

(Certificate of no value without full name of child.)

Sex of Child Female

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti-  
mate?

Yes

Date of  
birth

Oct 2nd  
1921  
(Month) (Day) (Year)

What bactericidal solution was used in eyes? sbp arg wot.

Number of child of this mother, including present birth 10

Number of child of this mother now living, including present birth 8

FULL  
NAME

FATHER

J. A. Burrey

FULL  
MAIDEN  
NAME

MOTHER

Mary E. Humphrey

RESIDENCE

Wardboro, Idaho

RESIDENCE

Wardboro, Idaho

COLOR

White

AGE AT LAST  
BIRTHDAY

42  
(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

41  
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Stockman

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated.

(Stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

W. H. King

(Physician or midwife)

Give names added from a supplemental report.

Address \_\_\_\_\_

Montpelier, Idaho

Filed \_\_\_\_\_

10-15 1921

W. H. King

Registrar.

Registrar.

TO  
OF WELFARE  
OFFICE

BIRTH

803760



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 35475

1. PLACE OF DEATH  
County of Bear Lake Registration District No. 52  
City of Montpelier Registration District No. 2136  
BUREAU OF VITAL STATISTICS  
2. FULL NAME Baby Berrey

Registered No. \_\_\_\_\_  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant  
(Write the word.)  
6. DATE OF BIRTH Oct 2 1921  
(Month) (Day) (Year)  
7. AGE Still Born IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE S. Montpelier Idaho  
(State or Country)

10. NAME OF FATHER J. A. Berrey

11. BIRTHPLACE OF FATHER Idaho  
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Humphrey

13. BIRTHPLACE OF MOTHER Idaho  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J. A. Berrey  
(Address) Montpelier

15. Filed 10-15-21 1921  
Local Registrar H. Humphrey

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:  
Still Born - Asphyxia Neonatorum (Following Placental Rupture)  
(Duration) 7 Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) H. Humphrey M. D.  
(Address) Montpelier

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.  
Where was disease contracted if not at place of death?  
Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL Montpelier Idaho DATE OF BURIAL 10-2-21  
20. UNDERTAKER Bert Simuk ADDRESS Montpelier

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

663-209-006-843

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of Spingham

## CERTIFICATE OF BIRTH

City of ShelleyRegistration District No. 121File No. S 94321

No. \_\_\_\_\_

St. \_\_\_\_\_

Primary Registration District No. 2194Registered No. 321

Hospital \_\_\_\_\_

FULL NAME OF CHILD Violet Louise FolsomSex of Child FemaleTwin  
Triplet  
or other?  
(To be answered only in event of plural births)and } Number  
in order  
of birthLegitimate? YesDate of Birth Sept 9

(Month) (Day)

1921  
(Year)FULL NAME Harry Allen Folsom

FATHER

FULL MAIDEN NAME Nettie Anne Kelt

MOTHER

RESIDENCE Shelley IdaRESIDENCE Shelley IdaCOLOR WhiteAGE AT LAST BIRTHDAY 21

(Years)

COLOR WhiteAGE AT LAST BIRTHDAY 20

(Years)

BIRTHPLACE NebraskaBIRTHPLACE Shelley IdaOCCUPATION InsuranceOCCUPATION HousewifeNumber of child of this mother, including present birth 1Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born dead on the date above stated.

(Born alive or stillborn)

at 5:30 P.M.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. P. Egbert

(Physician or midwife)

Given names added from a supplemental report.

19

Address Shelley IdaFiled Oct. 5 1921

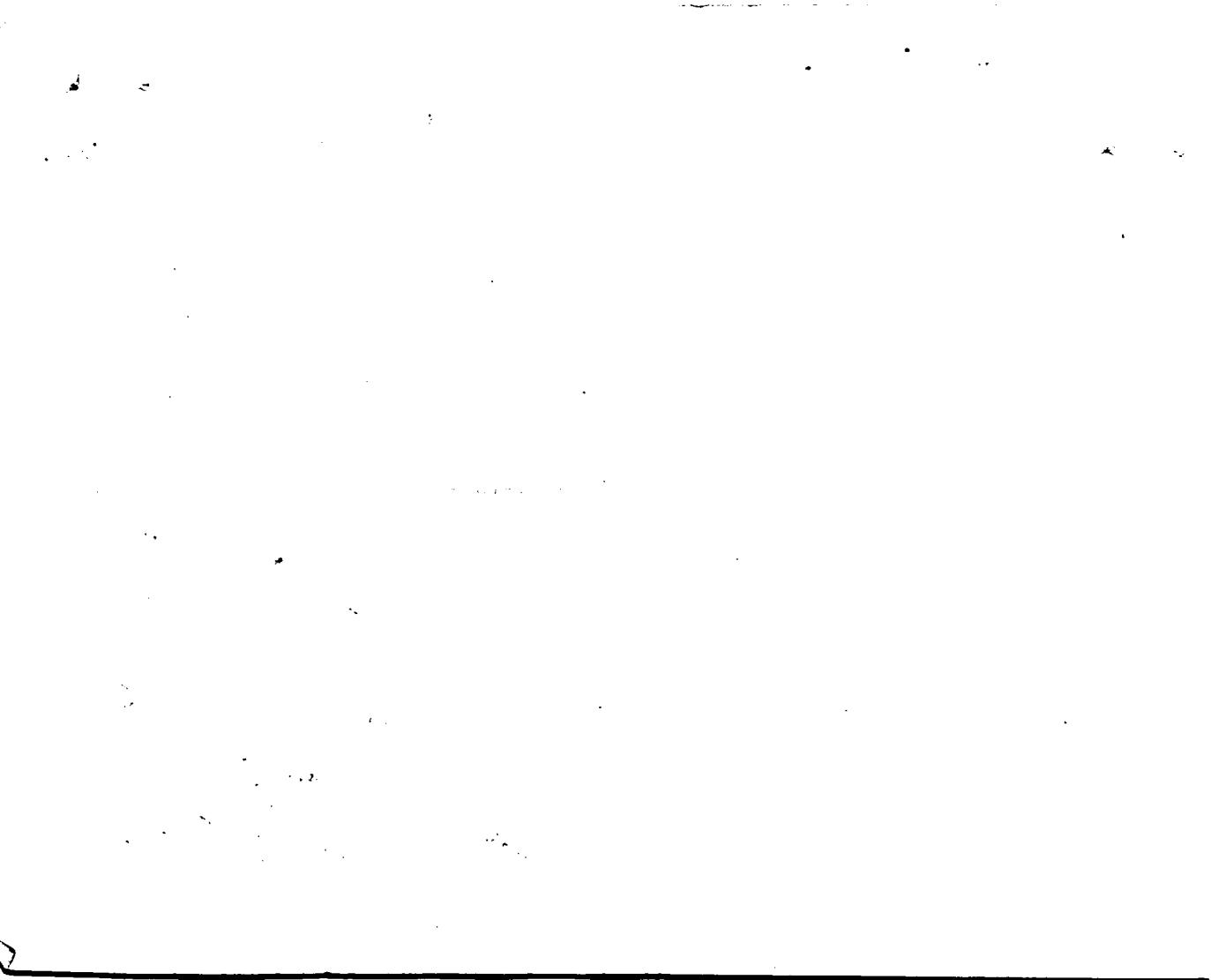
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Bingham Registration District No. 121  
 City of Shelley Registration District No. 2194  
 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Violet Louise Tolson

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 35488  
 Registered No. 124

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant  
 (Write the word.)

## 6. DATE OF BIRTH

Sept. 9 1921  
 (Month) (Day) (Year)

## 7. AGE

Infant IF LESS than 1 day how many hrs. or min.?  
Premature 7 months  
Still Born

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer).

Infant

## 9. BIRTHPLACE

(State or Country)

Shelley Ida

## 10. NAME OF FATHER

Harry Glen Tolson

## 11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

## 12. MAIDEN NAME OF MOTHER

Mattie Hult

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Shelley Ida

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Glen Tolson  
 (Address) Shelley Ida

## 15. Filed

Sept. 10 1921

Mrs. Helen E. Tolson

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sept. 9 1921  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Sept. 9 1921, to Sept. 9 1921  
 that I last saw him still Born alive on 19

and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH\* was as follows:

Premature  
Still Born 7 months  
 (Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) Yrs. mos. ds.  
 (Signed) D. R. Robert M. D.

Sept. 9 1921 (Address) Shelley Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shelley Ida 19

## 20. UNDERTAKER

ADDRESS

Harry Glen Tolson

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

731-115-009-118  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

94355

County of Bonneville  
City of Sandpoint  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 75 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2155 Registered No. \_\_\_\_\_  
FULL NAME OF CHILD Shelhorn Glasson  
(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>9-15</u> 192 <u>1</u> (Month) (Day) (Year)
--------------------------	--	-----	--------------------------------	-----------------------------	---

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 4

FATHER		MOTHER	
FULL NAME <u>Hubert Arundel Glasson</u>	FULL MAIDEN NAME <u>Alma Savina Jay</u>		
RESIDENCE <u>Sandpoint</u>	RESIDENCE <u>Sandpoint</u>		
COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR <u>W.</u> AGE AT LAST BIRTHDAY <u>29</u> (Years)		
BIRTHPLACE <u>Colorado</u>	BIRTHPLACE <u>Pennsylvania</u>		
OCCUPATION <u>Carpenter</u>	OCCUPATION <u>Law.</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 5:30 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

\_\_\_\_\_, 19\_\_\_\_

Registrar.

(Signature)

M. P. Wallentine

(Physician or midwife)

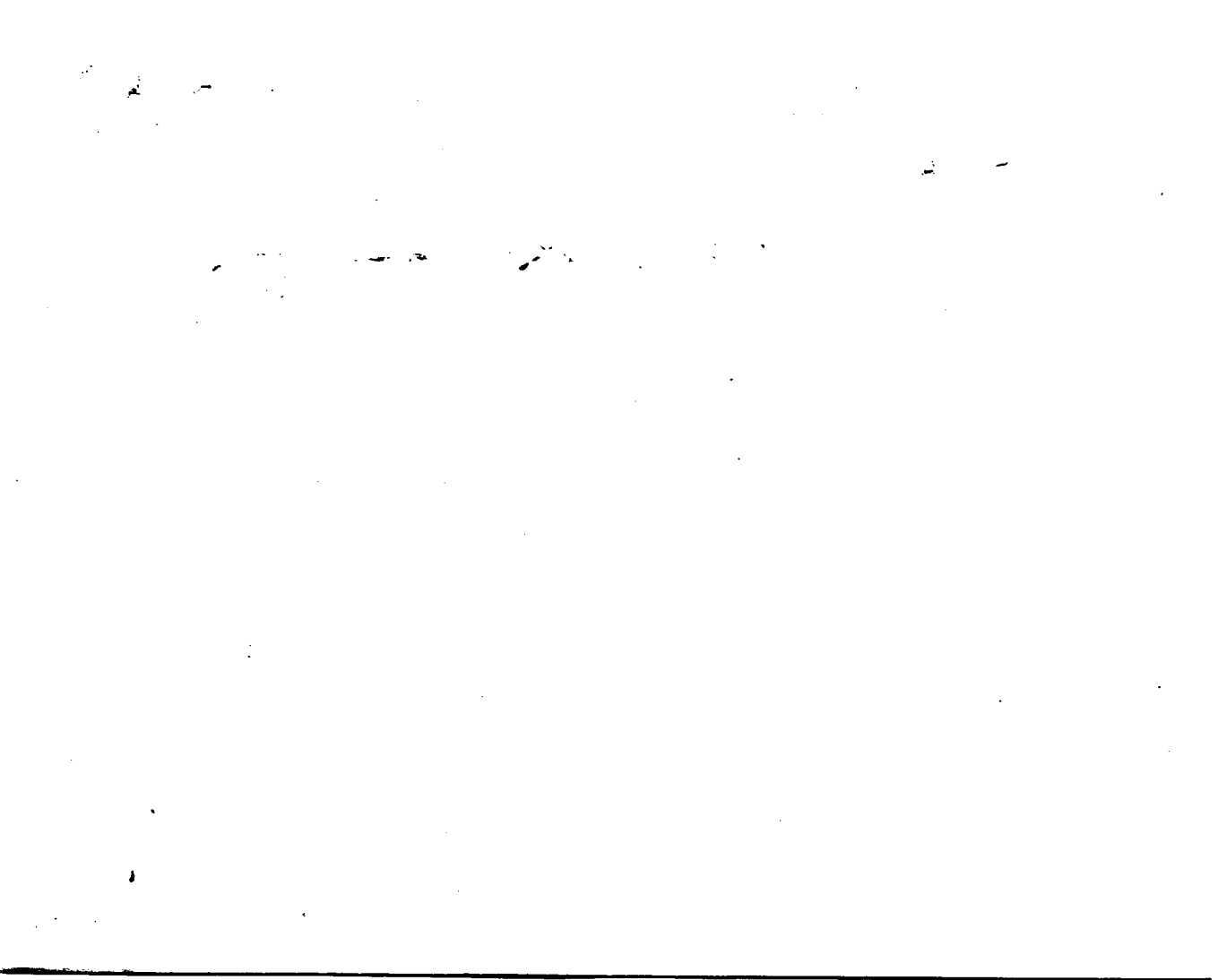
Address

Sandpoint

Filed

Oct 8 1921

Floyd G. Woodruff  
Registrar.





FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **35500**  
Registered No. \_\_\_\_\_

## 1. PLACE OF DEATH

County of **Bonne**  
City of **Sandpoint**

Registration District No. **75**  
Primary Registration District No. **2155**  
(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

**Stieborn**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**  
(Write the word.)

## 6. DATE OF BIRTH

**Sept. 15 1921**  
(Month) (Day) (Year)

## 7. AGE

**Stieborn**  
Mos. \_\_\_\_\_ ds. \_\_\_\_\_

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) **Idaho**

## 10. NAME OF FATHER

**Hubert A. Glason**

## 11. BIRTHPLACE OF FATHER

(State or Country) **Colorado**

## 12. MAIDEN NAME OF MOTHER

**Alma Irving Joy**

## 13. BIRTHPLACE OF MOTHER

(State or Country) **Penn**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **H. A. Glason**

(Address) **Sandpoint**

## 15.

Filed **Oct 8 1921** **Phyllis Wendle**  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

**Sept 15 1921**  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

**Stieborn** to \_\_\_\_\_

that I last saw him alive on \_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

**Stieborn**

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) **M. P. Wallentin** M. D.

19 \_\_\_\_\_ (Address) **Sandpoint**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

**Sandpoint**

## DATE OF BURIAL

**1921**

## 20. UNDERTAKER

## ADDRESS

**L**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name or origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

318-118-014-413

## PLACE OF BIRTH

RECEIVED

OCT 31 1921

STATE OF IDAHO

Form V. S. No. 11-C-25a-4-23

BUREAU OF VITAL STATISTICS

County of... Canyon

CERTIFICATE OF BIRTH

City of... Huston

BUREAU OF VITAL  
STATISTICS

Registration District No. ....

3

File No. ....

S 94448

No. .... St.

Primary Registration District No. .... 2005

Registered No. .... 203

Hospital .....

FULL NAME OF CHILD

Roy Edwards Taylor

Sex of  
Child

M

Twin  
Triplet  
or other?and { Number  
in order  
of birth  
(To be answered only in event of plural births)Legiti-  
mate?

yes

Date of  
BirthSept 18 1921  
(Month) (Day) (Year)FULL  
NAME

FATHER

Chas Everett Taylor

RESIDENCE

Huston Ida

COLOR

white

AGE AT LAST  
BIRTHDAY24  
(Years)

BIRTHPLACE

West Plains Mo

OCCUPATION

Depot agent

FULL  
MAIDEN  
NAME

MOTHER

Leona Bernice Matson

RESIDENCE

Huston Ida

COLOR

white

AGE AT LAST  
BIRTHDAY23  
(Years)

BIRTHPLACE

Utah

OCCUPATION

Housewife

Number of child of this mother, including present birth...?..... Number of children of this mother now living, including present birth...1.....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was..... still born..... at..... 6 A..... M.  
on the date above stated. (Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc., should  
make this return. A stillborn child is one that  
neither breathes nor shows other evidence of life  
after birth.

(Signature) .....

Edmond Montgomery M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address .....

Caldwell Idaho

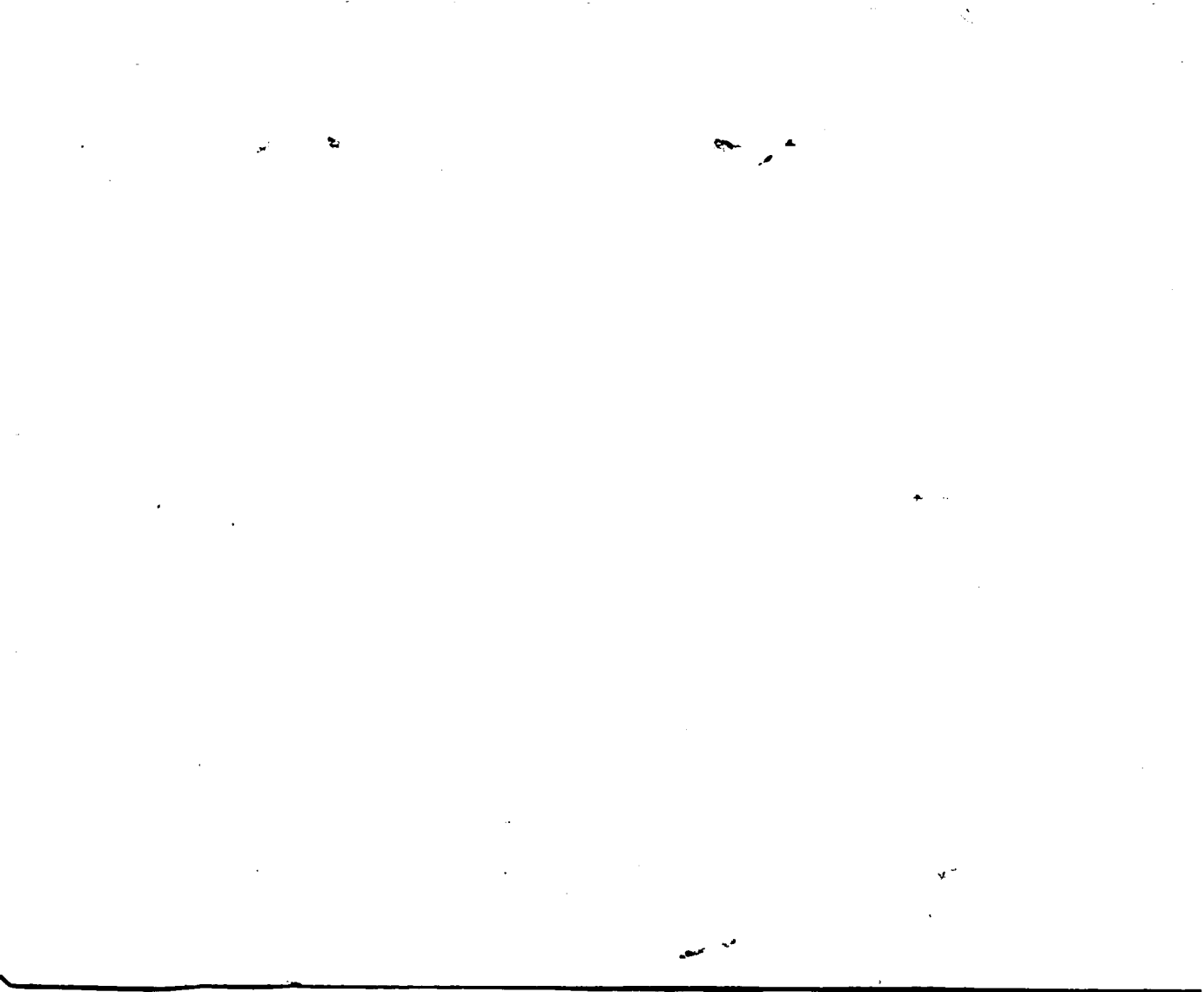
Filed .....

Sept 21 1921

John V. Meyer

Registrar

Registrar



RECEIVED

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of CanyonCity of Princeton

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Roy Edward Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
- 
- OWED OR DIVORCED

male white

(Write the word.)

## 6. DATE OF BIRTH

Sept 18 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

- (a) Trade, profession or particular kind of work
- 
- (b) General nature of industry, business or establishment in which employed (or employer)

At home

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Everett Taylor

## 11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

## 12. MAIDEN NAME OF MOTHER

Bessie Watson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Everett Taylor

(Address)

Princeton Idaho

## 15.

Filed Sept 19 1921John H. Meyer  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sept 18 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Sept 18 1921, to at birth 19  
that I last saw him alive on stillborn 19  
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Strangulation from cord about 1 wk before birth

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Montgomery M. D.Sept 19 1921 (Address) Caldwell, Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Kahler9-19-1921

## 20. UNDERTAKER

## ADDRESS

C. V. Beckham Caldwell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

189-6

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

962-221-014-633 RECEIVED

PLACE OF BIRTH

OCT 31 1921

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Chayon BUREAU OF VITAL STATISTICS

City of Nampa BUREAU OF VITAL STATISTICS

Registration District No. 7

File No. S 94481

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital Murray

Primary Registration District No. 1106

Registered No. \_\_\_\_\_

FULL NAME OF CHILD Robinson

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth (To be answered only in event of plural births)	Legitimacy <u>yes</u>	Date of Birth <u>8/21</u> (Month) (Day) (Year)
-------------------------------	---	-----	---	--------------------------	--

FULL NAME FATHER OR Robinson

FULL NAME MOTHER Elizabeth Otter

RESIDENCE North Platte Neb.

RESIDENCE North Platte Neb.

COLOR White AGE AT LAST BIRTHDAY 36  
(Years)

COLOR White AGE AT LAST BIRTHDAY 35  
(Years)

BIRTHPLACE Missouri

BIRTHPLACE Nebraska

OCCUPATION Laborer

OCCUPATION Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still Born at 7<sup>30</sup> a.m.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Leo N. Chilton M.D.

(Physician or midwife)

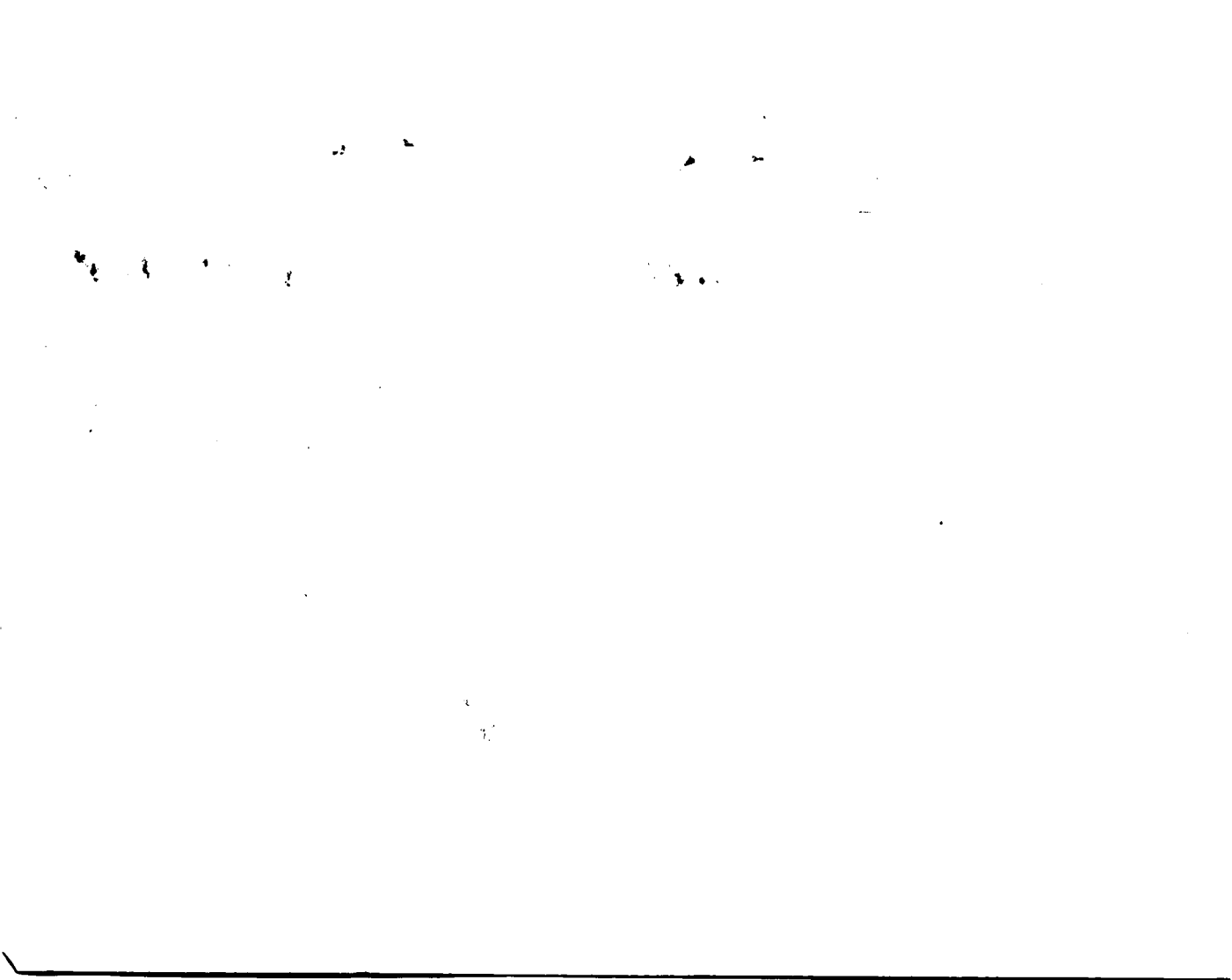
Given names added from a supplemental report.

Address Nampa Idaho

Filed Oct. 10 1921 Levin L. Larkin

Registrar

Registrar





CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH **OCT 3**

Registration District No. ....

County of **Campbell**

Primary Registration District No. **1886**

File No. **35535**

City of **Hampden**

(No. .... St.)

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

**Infant Robinson**

If death occurred in a hospital, institution or care, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **(Write the word.)**

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

**O. R. Robinson**

11. BIRTHPLACE OF FATHER

(State or Country) **Missouri**

12. MAIDEN NAME OF MOTHER

**Elizabeth Allen**

13. BIRTHPLACE OF MOTHER

(State or Country) **Nebraska**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed **Oct. 15** 19**21** **Charles Dodds**  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

**Aug 2** 19**21**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

**19** to **19**

that I last saw him alive on **19**

and that death occurred on the date stated above, at **11** M.

The CAUSE OF DEATH\* was as follows:

**Still born 6 months**

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Leo W. Chittenden** M. D.

**10/10/21** (Address) **Hampden Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

**Hampden**

DATE OF BURIAL

**8/21/1921**

20. UNDERTAKER

**None**

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

419-209-037-993

PLACE OF BIRTH

RECEIVED

UCT 31

OF IDAHO  
ITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Canyon

BUREAU OF

OF BIRTH

City of Reynolds Creek

STATISTICS

Registration District

File No.

S 94494

No. \_\_\_\_\_ St.

Primary Registration District No. 2006

Registered No.

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Baby Marmolejo

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>Sept 9</u> (Month) (Day) (Year) <u>1921</u>
----------------------------	---	-----	--------------------------------	-------------------------------	---

FULL NAME <u>Jerry J. Marmolejo</u>	FATHER
RESIDENCE <u>Reynolds Creek, Id</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>Nevada</u>	
OCCUPATION <u>Rancher</u>	

FULL MAIDEN NAME <u>Mathie Laura Richey</u>	MOTHER
RESIDENCE <u>Reynolds Creek, Id</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Pennsylvania</u>	
OCCUPATION <u>House wife</u>	

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 3 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Samuel A. Swaine  
(Physician or midwife) Melba, Id

Given names added from a supplemental report;

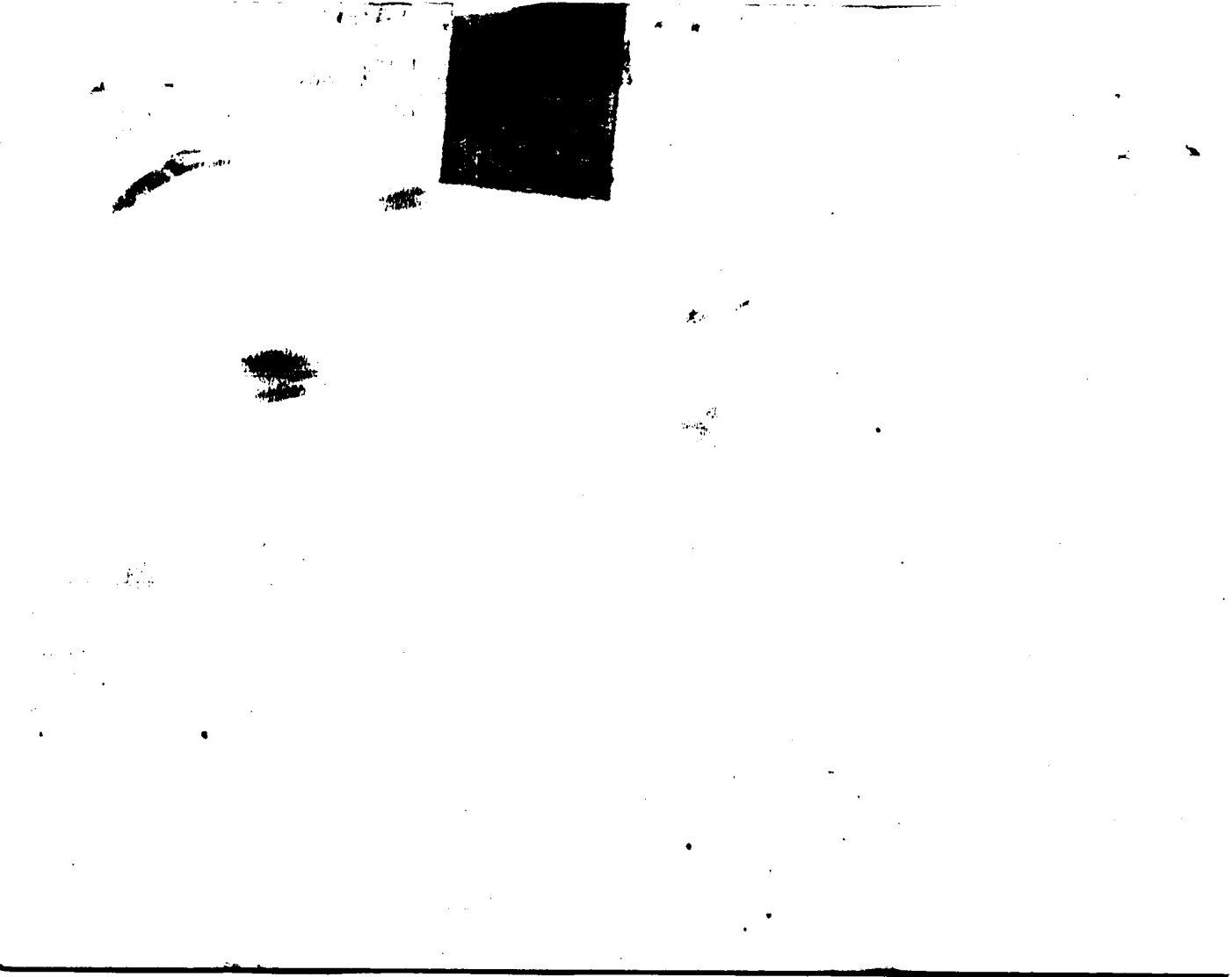
19

Address

Filed Oct 10 1921 Pearle Dodson

Registrar

Registrar



RECEIVED

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of OwyheeCity of Penolds Creek

If death occurs away from usual residence, give facts called for under special information.

OCT 31 1921

Registration District No. 7Primary Registration District No. 2056

STATES

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 35539

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

Virginia Marmolejo

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Sept.  
(Month)

(Day)

1921  
(Year)

## 7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day  
how many 0 hrs.  
or 0 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Owyhee, Idaho

## 10. NAME OF FATHER

Jerry J Marmolejo

## 11. BIRTHPLACE OF FATHER

(State or Country)

Nevada

## 12. MAIDEN NAME OF MOTHER

Mattie Sara Dickey

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mattie L. Marmolejo

(Address)

Penolds Creek, Id

## 15.

Filed Oct. 10 1921 Pearl D. Dodd

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sept.  
(Month)9  
(Day)1921  
(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Sept 9 1921, to Sept 9 1921that I last saw him alive on ✓ 19and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH\* was as follows:

Still birth, 5 1/2 months gestation. Cause of still birth unknown(Duration) Yrs. mos. ds.Contributory  
(Secondary)(Duration) yrs. mos. ds.

(Signed)

Samuel A. Sweeney M. D.19

(Address)

Melba, Id.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Penolds Creek

## DATE OF BURIAL

9 1921

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

215-120-016-719  
PLACE OF BIRTH

RECEIVED

OCT 31 1921

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S94511

County of Cassia  
City of Burley  
No. 117 St. 117BUREAU OF VITAL STATISTICS  
Registration District No. 117File No. 117Hospital Stillborn Primary Registration District No. 2196 Registered No. 2067FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>117</u>	Legitimate? <u>yes</u>	Date of birth <u>Sept 20</u> 1921
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? Silver NitrateNumber of child of this mother, including present birth 14 Number of child of this mother now living, including present birth 12

FULL NAME <u>L. M. Savage</u>	FATHER	FULL MAIDEN NAME <u>Maggie Garrison</u>	MOTHER
RESIDENCE <u>Burley, Ida.</u>		RESIDENCE <u>Burley, Ida.</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>42</u> (Years)
BIRTHPLACE <u>Arizona</u>		BIRTHPLACE <u>N. Mexico</u>	
OCCUPATION <u>Farming</u>		OCCUPATION <u>House wife</u>	

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn 7 P. M. on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. J. C. PattersonPhysician  
(Physician or midwife)

Give names added from a supplemental report.

Address Burley, Ida.Filed Sept 21 1921 D. J. C. Patterson

Registrar.

Registrar.

1

2

3

4



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## RECEIVED CERTIFICATE OF DEATH.

1. PLACE OF DEATH

County of Cassia District No. 117  
City of Burley Primary Registration District No. 2196  
State Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn  
Infant

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 35971Registered No. 245

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

WSingle  
(Write the word.)

6. DATE OF BIRTH

Sept  
(Month)20  
(Day)1921  
(Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or  
min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Levi M. Savage

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Maggie M. Garvin

13. BIRTHPLACE OF MOTHER

(State or Country)

Newmed

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Levi M. Savage

(Address)

Burley

15.

Filed

Sept 211921R. J. C. Patterson

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept  
(Month)20  
(Day)1921  
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191191that I last saw him alive on 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Patterson M. D.

7-21-1921 (Address)

Burley, Ida.

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley, Ida.Sept 21 1921

20. UNDERTAKER

ADDRESS

R. J. C. PattersonBurley

6  
-  
9  
6  
1

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

685-108-016-847

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Cassia OCT 31 1921

CERTIFICATE OF BIRTH

City of Albion BUREAU OF VITAL  
STATISTICS

Registration District No. 119

File No. 94546

No. 1 St.

Hospital at home

Primary Registration District No.

Registered No.

FULL NAME OF CHILD

Sex of Child <u>Male</u>	Twin Triplet or other? <u>—</u> (To be answered only in event of plural births)	and	Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	Date of Birth <u>Sept 8</u> 19 <u>21</u> (Month) (Day) (Year)
--------------------------	--	-----	-----------------------------------	------------------------	--

FATHER  
FULL NAME Wallace Wheeler  
RESIDENCE Walt Albion Ida  
COLOR white AGE AT LAST BIRTHDAY 30 (Years)  
BIRTHPLACE Walsburg Utah  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Myrtle Hughes  
RESIDENCE Albion Idaho  
COLOR white AGE AT LAST BIRTHDAY 29 (Years)  
BIRTHPLACE Heber Utah  
OCCUPATION House wife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive stillborn at 11:40 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

E. J. Sater M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

Address Walt Albion Idaho

Filed Oct 1 1921

Registrar

E. J. Sater  
Registrar



FORM V. S. No. 5-25 M. 1-16-**RECEIVED**

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH, **OCT 31 1921**  
 County of **Cassia** Registration District No. **119**  
 City of **Albion** Primary Registration District No. \_\_\_\_\_  
 (No. \_\_\_\_\_) St. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME \_\_\_\_\_

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. **35545**

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**  
 (Write the word.)

6. DATE OF BIRTH. **Sept 8 1921**  
 (Month) (Day) (Year)

7. AGE **still born** IF LESS than 1 day  
 how many \_\_\_\_\_ hrs. or  
 \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
 (b) General nature of industry, business, or establishment in which employed (or employer).....

**Infant**

## 9. BIRTHPLACE

(State or Country)

**Albion Idaho**

## 10. NAME OF FATHER

**Wallace Wheeler**

## 11. BIRTHPLACE OF FATHER

(State or Country)

**Washington Utah**

## 12. MAIDEN NAME OF MOTHER

**Myrtle Hughes**

## 13. BIRTHPLACE OF MOTHER

(State or Country)

**Idaho Utah**

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

**Myrtle Wheeler  
Albion Idaho**

15.

Filed

**Oct 1 1921****C. J. Sater**

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept 8 1921**  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **still born** 191...  
 that I last saw h. alive on 191...  
 and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

**unknown, died in utero**

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

10/1 1921 (Address) **Albion Idaho**

\*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days. In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

**Albion Idaho****Sept 8 1921**

## 20. UNDERTAKER

## ADDRESS

**None**

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death ), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

296-110-026-339  
PLACE OF BIRTHSTATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of

City of

No.

Hospital

FULL NAME OF CHILD

BUREAU OF VITAL  
STATISTICS

Registration District No.

CERTIFICATE OF BIRTH

File No.

S  
94681

Primary Registration District No.

Registered No.

Sex of  
Child

m

Twin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti-  
mate?

yes

Date of  
BirthJune 10, 1924  
(Month) (Day) (Year)FULL  
NAME

J. I. Brown

FATHER

FULL  
MAIDEN  
NAME

Ella Clifford

MOTHER

RESIDENCE

Rigby #3

RESIDENCE

same

COLOR

W

AGE AT LAST  
BIRTHDAY36  
(Years)

COLOR

W

AGE AT LAST  
BIRTHDAY26  
(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

At home

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.stillborn at 12 A. M.  
(Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

A. M. Palmer

Given names added from a supplemental report.

19

Address

(Physician or midwife)

Filed

Rigby  
10/10/24  
Ray Fisher  
Registrar.

Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

Dup of 1921-94755



## PLACE OF DEATH.

**CERTIFICATE OF DEATH**

**RECEIVED**

Registration District No. 98

Primary Registration District No. 2176

**BUREAU OF VITAL STATISTICS**

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 35579

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

County of Jefferson  
City of Rigby

death occurs away from usual residence, give facts needed for under special formation.

2. FULL NAME No name! Stillborn

## PERSONAL AND STATISTICAL PARTICULARS

SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M | White | Babe  
(Write the word.)

DATE OF BIRTH.

June 10 1921  
(Month) (Day) (Year)

AGE Still born  
IF LESS than 1 day  
how many \_\_\_\_\_ hrs. or  
\_\_\_\_\_ min. 2

## OCCUPATION

Trade, profession or particular kind of work.  
General nature of industry, business, or establishment in which employed (or employer).

## BIRTHPLACE

(State or Country)

## NAME OF FATHER

## BIRTHPLACE OF FATHER

(State or Country)

## MAIDEN NAME OF MOTHER

## BIRTHPLACE OF MOTHER

(State or Country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Informant) J. L. Brown

(Address) Rigby, Ida.

d Oct 10 1921 Ray Fisher  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 10 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191  
that I last saw him alive on 191

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn  
(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) A. M. Palmer M. D.

19 (Address) Rigby, Idaho

\*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....Mos.....Days In the State.....Yrs.....Mos.....Days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rigby, Ida. June 10, 1921

20. UNDERTAKER ADDRESS

Friends Rigby, Ida.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lung meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.,* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL or as *probably* such, if impossible to determine definite. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poison by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *septic tetanus*) may be stated under the head of "Contributor

392-215-026-713  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

S94682

County of JeffersonCity of BoothBUREAU OF VITAL STATISTICS  
Registration District No. 98

File No.

No. \_\_\_\_\_ St.

Primary Registration District No. 2176 Registered No. 260

Hospital \_\_\_\_\_

FULL NAME OF CHILD Nelson TibbettsSex of Child 7Twin  
Triplet  
or other?  
(To be answered only in event of plural births)and { Number  
in order  
of birthLegitimate? yesDate of Birth June 15, 21

(Month) (Day) (Year)

FULL NAME

FATHER

Emmett Tibbetts

FULL MAIDEN NAME

MOTHER

Mary Talbraith

RESIDENCE

Lorenzo

RESIDENCE

Lorenzo

COLOR

W

AGE AT LAST BIRTHDAY

23

(Years)

COLOR

W

AGE AT LAST BIRTHDAY

23

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Utah

OCCUPATION

Farmer

OCCUPATION

at homeNumber of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was alive at 8:30 P. M. on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) A. M. Palmer

(Physician or midwife)

Given names added from a supplemental report.

Address RigbyFiled 10/26Ray Fisher  
Registrar.

Registrar.

2

# STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

NOV 23 1921

BUREAU OF  
STATISTICS

NOV 10 1921

Boise, Idaho, .....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City Loreny ..... File Number 94682 .....  
 { Street .....  
 { County Jeff .....  
 Sex of Child Female ..... Date of Birth June 15 ..... 1921..  
 Father Bernard Emmett Tibbitts ..... Mother Mary Bodily Tibbitts .....  
 Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Child's Name in Full

Baby was still born  
 Signature of Father or Mother  
Mr. Emmett Tibbitts  
Mrs. Mary B. Tibbitts

11

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

5157141-027-613

PLACE OF BIRTH

RECEIVED

Form V. S. No. 11-C-25m-7-21-19

OCT 31 1921

STATE OF IDAHO

BUREAU OF VITAL STATISTICS

County of Jerome

BUREAU OF VITAL STATISTICS

City of Jerome

Registration District No. 23

File No. 94757

No. \_\_\_\_\_ St. 1017

Primary Registration District No. 2017

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

unnamed Van Marton

Sex of Child male

Twin  
Triplet  
or other?

— and —

Number  
in order  
of birth  
(To be answered only in event of plural births)

Legiti  
mate? yes

Date of Birth Aug 14 1921  
(Month) (Day) (Year)

FULL  
NAME

George W. Van Marton

RESIDENCE

Jerome

COLOR

white

AGE AT LAST  
BIRTHDAY

23  
(Years)

BIRTHPLACE

Illinois

OCCUPATION

Farmer

FULL  
MAIDEN  
NAME

Franca Eliza Walker

RESIDENCE

Jerome

COLOR

white

AGE AT LAST  
BIRTHDAY

22  
(Years)

BIRTHPLACE

Nebraska

OCCUPATION

House wife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still born, at 6 a. m.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Edith Chaffee

Registered Nurse

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Jerome Idaho

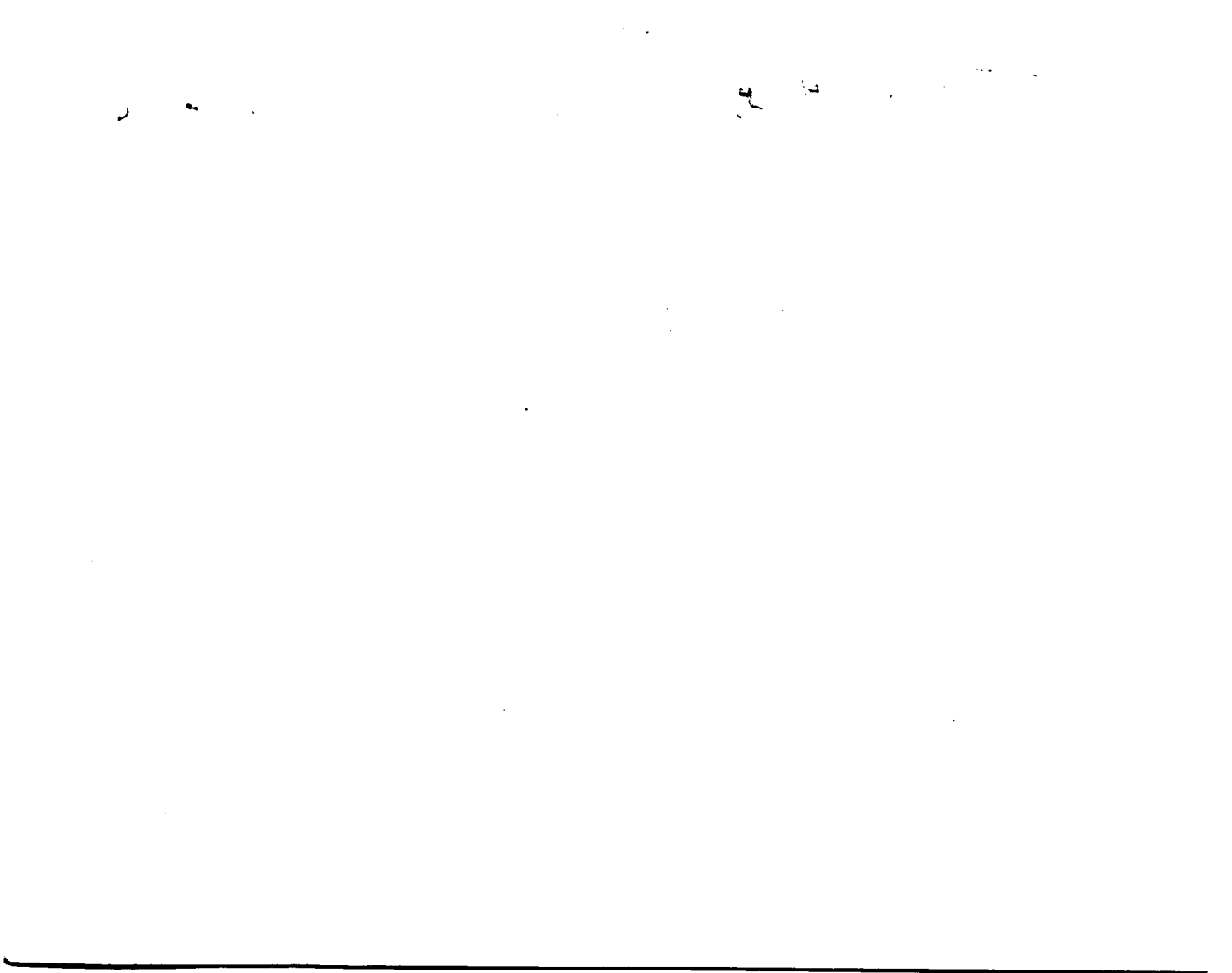
Filed

Oct 11 1921

E. D. P. M. D.

Registrar

Registrar





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Jerome Registration District No. 23  
City of Jerome, Idaho Primary Registration District No. 1012-2017  
(No. 1012-2017 St.)

File No. 40556  
Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Van Nostran

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

August 14 1921  
(Month) (Day) (Year)

## 7. AGE

Stillborn  
0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Jerome, Idaho, R.D.

## 10. NAME OF FATHER

George H. Van Nostran

## 11. BIRTHPLACE OF FATHER

(State or Country) Illinois, U.S.A.

## 12. MAIDEN NAME OF MOTHER

Frances Eliza Walker

## 13. BIRTHPLACE OF MOTHER

(State or Country) Nebraska

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edith Chaffee, R.N.  
(Address) Jerome, Idaho

15. Dec 14 1922 E. D. P. P. M. D.  
Filed Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

August 14 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillbirth, very low, have been due to the mother falling, and delivery occurred at

7 1/2 mos. (Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Edith Chaffee M. D.

\_\_\_\_\_ 19\_\_\_\_ (Address) Jerome, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

On the farm Aug. 14 1921

## 20. UNDERTAKER ADDRESS

Edith

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Stillbirth - probable cause - mother fell  
delivery occurred at <sup>about</sup> 7½ mos.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

386 118-027-895  
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Jerome RECEIVED DEPARTMENT OF PUBLIC WELFARE  
City of Jerome OCT 31 1921 BUREAU OF VITAL STATISTICS  
No. 23 Certificate of Birth

Hospital home St. 1017 File No. 94777  
Primary Registration District No. 247 Registered No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin <u>other</u> and Number in order of birth <u>6</u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth... <u>June 18</u> 1921 (Month) (Day) (Year)
-----------------------	--	------------------------	--

What bacteriocidal solution was used in eyes?.....

Number of child of this mother, including present birth... 6 Number of children of this mother now living, including present birth... 4

FATHER FULL NAME <u>Carley G. Thompson</u> RESIDENCE <u>Jerome, Ida.</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>36</u> (Years) BIRTHPLACE <u>Utah</u> OCCUPATION <u>Farming</u>	MOTHER FULL MAIDEN NAME <u>Elizabeth Hinsaker</u> RESIDENCE <u>Jerome, Ida.</u> COLOR <u>white</u> AGE AT LAST BIRTHDAY <u>32</u> (Years) BIRTHPLACE <u>Utah</u> OCCUPATION <u>Housewife</u>
--	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn 5:00 P.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Chas. F. Zeller  
M.H.  
(Physician or midwife)

Give names added from a supplemental report.

....., 1921

Address Jerome, Ida.  
Filed Oct 11 1921 J. D. Piper M.D.  
Registrar.



922-208-028-559  
PLACE OF BIRTHSTATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE—  
BUREAU OF VITAL STATISTICS

S

County of Kootenai RECEIVED OCT 31 1921  
City of Conrad BUREAU OF VITAL STATISTICS  
No. Radina St. Registration District No. 30 File No. 94800  
Hospital \_\_\_\_\_ Primary Registration District No. 1057 Registered No. 1091  
FULL NAME OF CHILD Mary Isakorha  
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other (To be answered only in event of plural births)	Number in order of birth <u>one</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Sept 8</u> (Month) (Day) (Year) <u>1921</u>
----------------------------	--	---	-----------------------------	--

What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth... 3 Number of child of this mother now living, including present birth... 2

FULL NAME <u>Father Gust Isakorha</u>	FULL MAIDEN NAME <u>Mother Vera Anna Vera</u>
RESIDENCE <u>Conrad</u>	RESIDENCE <u>Conrad</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>48</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Hungary</u>	BIRTHPLACE <u>Hungary</u>
OCCUPATION <u>mill worker</u>	OCCUPATION <u>Housewife</u>

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 8 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Koedler

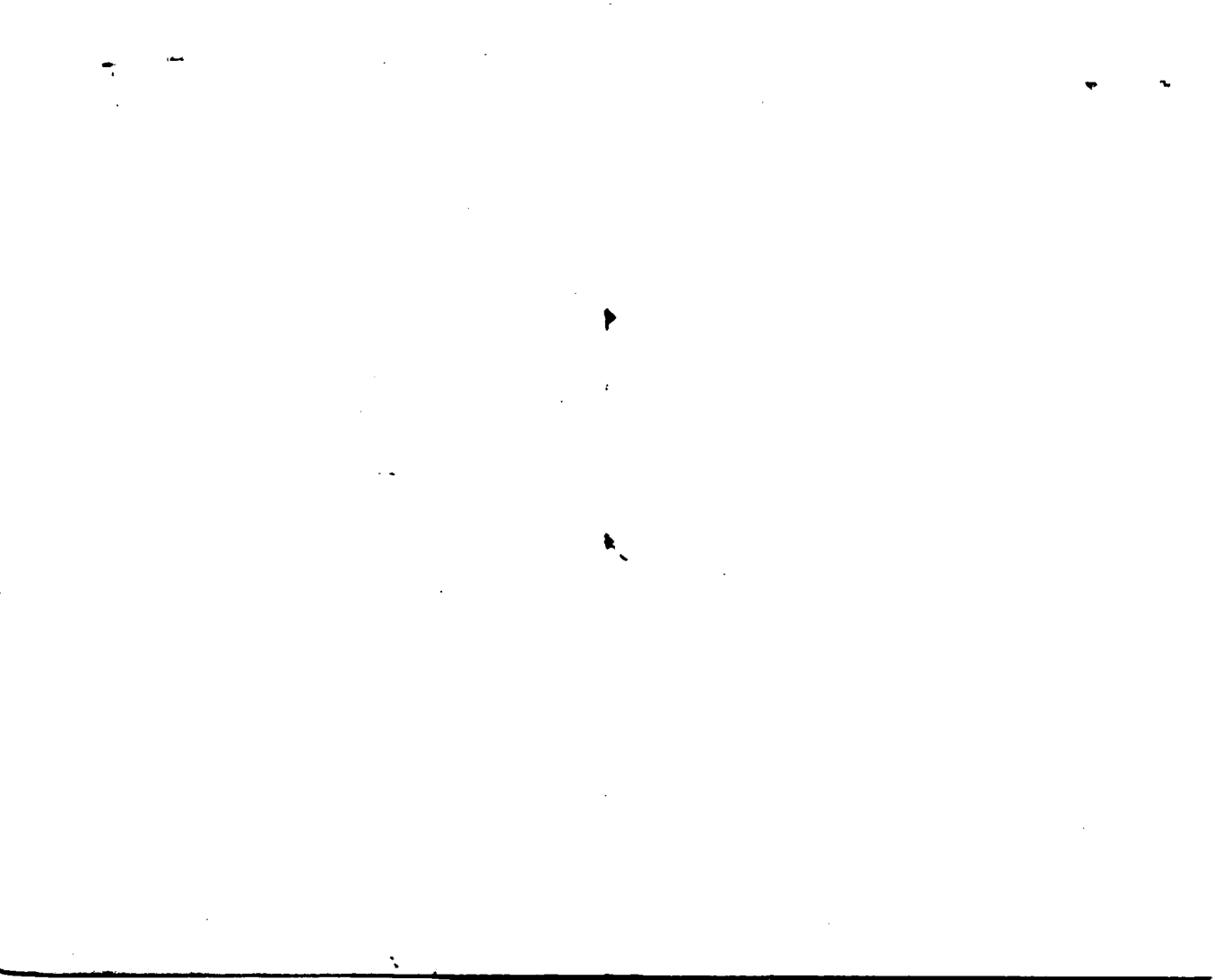
(Physician or midwife)

Give names added from a supplemental report.

Address ConradFiled Oct 7 1921 D. D. Drena

Registrar.

Registrar.



1. PLACE OF DEATH <i>Kootenai</i>		RECEIVED OCT 31 1921		CERTIFICATE OF DEATH 30		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
County of <i>Gibbs</i>		Registration District No. <i>1001</i>		Primary Registration District No. <i>1001</i>		File No. <i>35592</i>	
City of <i>Gibbs</i>		BUREAU OF VITAL STATISTICS		St.		Registered No. <i>987</i>	
If death occurs away from usual residence, give facts called for under special information.				2. FULL NAME <i>Mary Iskerka</i>		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>F.</i>	4. COLOR OR RACE <i>W.</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <i>single</i> (Write the word.)
6. DATE OF BIRTH <i>Sept. 8 1921</i> (Month) (Day) (Year)		
7. AGE <i>—</i> Yrs. <i>—</i> Mos. <i>—</i> ds.		IF LESS than 1 day how many <i>0</i> hrs. or <i>0</i> min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) *Idaho*

## 10. NAME OF FATHER

*Gust Iskerka*

## 11. BIRTHPLACE OF FATHER

(State or Country) *Hungary*

## 12. MAIDEN NAME OF MOTHER

*Anna Veria*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Hungary*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Gust Iskerka*  
(Address) *Gibbs, Id.*

15. Filed *Oct 4 1921* *D. W. Drennan*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Sept 8 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *19* to *19*  
that I last saw him alive on *19*  
and that death occurred on the date stated above, at *—* M.  
The CAUSE OF DEATH\* was as follows:

*Still Born. Hydrocephalus*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. H. Kessler* M. D.

*Sept 9 1921* (Address) *Coverd Allen Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *St. Thomas C.D. Allen* DATE OF BURIAL *9-9 1921*

20. UNDERTAKER *C. Cassey* ADDRESS *C. Dalena*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



345-1021030-892

PLACE OF BIRTH

Form V. S. No. 11-C-25m-9-8-15

RECEIVED BUREAU OF VITAL STATISTICS

OCT 31 1921

CERTIFICATE OF BIRTH

S 94841

County of Lemhi

City of Salmon

BUREAU OF VITAL  
STATISTICS

Registration District No.

41

File No.

No. St.

Primary Registration District No. 2116

Registered No.

Hospital

FULL NAME OF CHILD

Matter James Lund

Sex of Child Male

Twin  
Triplet  
or other?{ and } Number  
in order  
of birthLegiti-  
mate?

Yes

Date of  
Birth10-2-21  
(Month) (Day) (Year)

(To be answered only in event of plural births)

FULL  
NAMEFATHER  
Matter Henry LundFULL  
MAIDEN  
NAME

MOTHER

Lunny Ella Helbo

RESIDENCE

Salmon, Ida

RESIDENCE

Idaho.

COLOR

White

AGE AT LAST

BIRTHDAY  
(Years)

COLOR

White

AGE AT LAST

BIRTHDAY  
(Years)

BIRTHPLACE

Montana

BIRTHPLACE

Idaho.

OCCUPATION

Rubber.

OCCUPATION

Housewife

Number of child of this mother, including present birth.

One

Number of children of this mother now living, including present birth

None

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE \*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

(Signature)

(Both alive or stillborn)

1:30 P.M.

\* When there was no attending physician or  
midwife, then the father, householder, etc., should  
make this return. A stillborn child is one that  
neither breathes nor shows other evidence of life  
after birth.

Given names added from a supplemental report.

Address

Salmon, Idaho

Filed

10-10-1921

Cliff Bellamy

Registral

# INDICATING RECORDS FOR BIRTHING

WRITE PLAINLY IN INK WITH VULGARIZING AND NOT IN PENCIL OR IN RED INK. THE RECORDS ARE TO BE KEPT IN A SAFE PLACE AND NOT TO BE LOST OR DESTROYED.

THESE RECORDS ARE TO BE KEPT IN A SAFE PLACE AND NOT TO BE LOST OR DESTROYED.

## FULL NAME OF CHILD

NAME  
FULL  
NAME  
CHILD

RESIDENCE

COLOR

BIRTHPLACE

OCCUPATION

SEX OF CHILD

DATE OF BIRTH

TIME OF BIRTH

WEIGHT OF CHILD

LENGTH OF CHILD

HEAD CIRCUMFERENCE

ARM CIRCUMFERENCE

LEG CIRCUMFERENCE

FEET CIRCUMFERENCE

HAIR COLOR

EYES COLOR

SKIN COLOR

TEETH

HEALTH

FEEDING

SLEEPING

WALKING

TALKING

PLAYING

OTHER

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of the child who was

born on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_

\_\_\_\_\_ (Name of child) \_\_\_\_\_ (Sex of child)

\_\_\_\_\_ (Date of birth) \_\_\_\_\_ (Time of birth)

\_\_\_\_\_ (Weight of child) \_\_\_\_\_ (Length of child)

\_\_\_\_\_ (Head circumference) \_\_\_\_\_ (Arm circumference)

\_\_\_\_\_ (Leg circumference) \_\_\_\_\_ (Feet circumference)

\_\_\_\_\_ (Hair color) \_\_\_\_\_ (Eyes color)

\_\_\_\_\_ (Skin color) \_\_\_\_\_ (Teeth)

\_\_\_\_\_ (Health) \_\_\_\_\_ (Feeding)

\_\_\_\_\_ (Sleeping) \_\_\_\_\_ (Walking)

\_\_\_\_\_ (Talking) \_\_\_\_\_ (Playing)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of physician or midwife)

\_\_\_\_\_ (Address of physician or midwife)

\_\_\_\_\_ (City of physician or midwife)

\_\_\_\_\_ (State of physician or midwife)

\_\_\_\_\_ (Country of physician or midwife)

\_\_\_\_\_ (Date of certificate)

\_\_\_\_\_ (Time of certificate)

\_\_\_\_\_ (Place of certificate)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of parent)

\_\_\_\_\_ (Address of parent)

\_\_\_\_\_ (City of parent)

\_\_\_\_\_ (State of parent)

\_\_\_\_\_ (Country of parent)

\_\_\_\_\_ (Date of parent's signature)

\_\_\_\_\_ (Time of parent's signature)

\_\_\_\_\_ (Place of parent's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of registrar)

\_\_\_\_\_ (Address of registrar)

\_\_\_\_\_ (City of registrar)

\_\_\_\_\_ (State of registrar)

\_\_\_\_\_ (Country of registrar)

\_\_\_\_\_ (Date of registrar's signature)

\_\_\_\_\_ (Time of registrar's signature)

\_\_\_\_\_ (Place of registrar's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of hospital)

\_\_\_\_\_ (Address of hospital)

\_\_\_\_\_ (City of hospital)

\_\_\_\_\_ (State of hospital)

\_\_\_\_\_ (Country of hospital)

\_\_\_\_\_ (Date of hospital's signature)

\_\_\_\_\_ (Time of hospital's signature)

\_\_\_\_\_ (Place of hospital's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of doctor)

\_\_\_\_\_ (Address of doctor)

\_\_\_\_\_ (City of doctor)

\_\_\_\_\_ (State of doctor)

\_\_\_\_\_ (Country of doctor)

\_\_\_\_\_ (Date of doctor's signature)

\_\_\_\_\_ (Time of doctor's signature)

\_\_\_\_\_ (Place of doctor's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of nurse)

\_\_\_\_\_ (Address of nurse)

\_\_\_\_\_ (City of nurse)

\_\_\_\_\_ (State of nurse)

\_\_\_\_\_ (Country of nurse)

\_\_\_\_\_ (Date of nurse's signature)

\_\_\_\_\_ (Time of nurse's signature)

\_\_\_\_\_ (Place of nurse's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of mother)

\_\_\_\_\_ (Address of mother)

\_\_\_\_\_ (City of mother)

\_\_\_\_\_ (State of mother)

\_\_\_\_\_ (Country of mother)

\_\_\_\_\_ (Date of mother's signature)

\_\_\_\_\_ (Time of mother's signature)

\_\_\_\_\_ (Place of mother's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of father)

\_\_\_\_\_ (Address of father)

\_\_\_\_\_ (City of father)

\_\_\_\_\_ (State of father)

\_\_\_\_\_ (Country of father)

\_\_\_\_\_ (Date of father's signature)

\_\_\_\_\_ (Time of father's signature)

\_\_\_\_\_ (Place of father's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of registrar)

\_\_\_\_\_ (Address of registrar)

\_\_\_\_\_ (City of registrar)

\_\_\_\_\_ (State of registrar)

\_\_\_\_\_ (Country of registrar)

\_\_\_\_\_ (Date of registrar's signature)

\_\_\_\_\_ (Time of registrar's signature)

\_\_\_\_\_ (Place of registrar's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of hospital)

\_\_\_\_\_ (Address of hospital)

\_\_\_\_\_ (City of hospital)

\_\_\_\_\_ (State of hospital)

\_\_\_\_\_ (Country of hospital)

\_\_\_\_\_ (Date of hospital's signature)

\_\_\_\_\_ (Time of hospital's signature)

\_\_\_\_\_ (Place of hospital's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of doctor)

\_\_\_\_\_ (Address of doctor)

\_\_\_\_\_ (City of doctor)

\_\_\_\_\_ (State of doctor)

\_\_\_\_\_ (Country of doctor)

\_\_\_\_\_ (Date of doctor's signature)

\_\_\_\_\_ (Time of doctor's signature)

\_\_\_\_\_ (Place of doctor's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of nurse)

\_\_\_\_\_ (Address of nurse)

\_\_\_\_\_ (City of nurse)

\_\_\_\_\_ (State of nurse)

\_\_\_\_\_ (Country of nurse)

\_\_\_\_\_ (Date of nurse's signature)

\_\_\_\_\_ (Time of nurse's signature)

\_\_\_\_\_ (Place of nurse's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of mother)

\_\_\_\_\_ (Address of mother)

\_\_\_\_\_ (City of mother)

\_\_\_\_\_ (State of mother)

\_\_\_\_\_ (Country of mother)

\_\_\_\_\_ (Date of mother's signature)

\_\_\_\_\_ (Time of mother's signature)

\_\_\_\_\_ (Place of mother's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of father)

\_\_\_\_\_ (Address of father)

\_\_\_\_\_ (City of father)

\_\_\_\_\_ (State of father)

\_\_\_\_\_ (Country of father)

\_\_\_\_\_ (Date of father's signature)

\_\_\_\_\_ (Time of father's signature)

\_\_\_\_\_ (Place of father's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of registrar)

\_\_\_\_\_ (Address of registrar)

\_\_\_\_\_ (City of registrar)

\_\_\_\_\_ (State of registrar)

\_\_\_\_\_ (Country of registrar)

\_\_\_\_\_ (Date of registrar's signature)

\_\_\_\_\_ (Time of registrar's signature)

\_\_\_\_\_ (Place of registrar's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of hospital)

\_\_\_\_\_ (Address of hospital)

\_\_\_\_\_ (City of hospital)

\_\_\_\_\_ (State of hospital)

\_\_\_\_\_ (Country of hospital)

\_\_\_\_\_ (Date of hospital's signature)

\_\_\_\_\_ (Time of hospital's signature)

\_\_\_\_\_ (Place of hospital's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of doctor)

\_\_\_\_\_ (Address of doctor)

\_\_\_\_\_ (City of doctor)

\_\_\_\_\_ (State of doctor)

\_\_\_\_\_ (Country of doctor)

\_\_\_\_\_ (Date of doctor's signature)

\_\_\_\_\_ (Time of doctor's signature)

\_\_\_\_\_ (Place of doctor's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of nurse)

\_\_\_\_\_ (Address of nurse)

\_\_\_\_\_ (City of nurse)

\_\_\_\_\_ (State of nurse)

\_\_\_\_\_ (Country of nurse)

\_\_\_\_\_ (Date of nurse's signature)

\_\_\_\_\_ (Time of nurse's signature)

\_\_\_\_\_ (Place of nurse's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of mother)

\_\_\_\_\_ (Address of mother)

\_\_\_\_\_ (City of mother)

\_\_\_\_\_ (State of mother)

\_\_\_\_\_ (Country of mother)

\_\_\_\_\_ (Date of mother's signature)

\_\_\_\_\_ (Time of mother's signature)

\_\_\_\_\_ (Place of mother's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of father)

\_\_\_\_\_ (Address of father)

\_\_\_\_\_ (City of father)

\_\_\_\_\_ (State of father)

\_\_\_\_\_ (Country of father)

\_\_\_\_\_ (Date of father's signature)

\_\_\_\_\_ (Time of father's signature)

\_\_\_\_\_ (Place of father's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of registrar)

\_\_\_\_\_ (Address of registrar)

\_\_\_\_\_ (City of registrar)

\_\_\_\_\_ (State of registrar)

\_\_\_\_\_ (Country of registrar)

\_\_\_\_\_ (Date of registrar's signature)

\_\_\_\_\_ (Time of registrar's signature)

\_\_\_\_\_ (Place of registrar's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of hospital)

\_\_\_\_\_ (Address of hospital)

\_\_\_\_\_ (City of hospital)

\_\_\_\_\_ (State of hospital)

\_\_\_\_\_ (Country of hospital)

\_\_\_\_\_ (Date of hospital's signature)

\_\_\_\_\_ (Time of hospital's signature)

\_\_\_\_\_ (Place of hospital's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of doctor)

\_\_\_\_\_ (Address of doctor)

\_\_\_\_\_ (City of doctor)

\_\_\_\_\_ (State of doctor)

\_\_\_\_\_ (Country of doctor)

\_\_\_\_\_ (Date of doctor's signature)

\_\_\_\_\_ (Time of doctor's signature)

\_\_\_\_\_ (Place of doctor's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of nurse)

\_\_\_\_\_ (Address of nurse)

\_\_\_\_\_ (City of nurse)

\_\_\_\_\_ (State of nurse)

\_\_\_\_\_ (Country of nurse)

\_\_\_\_\_ (Date of nurse's signature)

\_\_\_\_\_ (Time of nurse's signature)

\_\_\_\_\_ (Place of nurse's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of mother)

\_\_\_\_\_ (Address of mother)

\_\_\_\_\_ (City of mother)

\_\_\_\_\_ (State of mother)

\_\_\_\_\_ (Country of mother)

\_\_\_\_\_ (Date of mother's signature)

\_\_\_\_\_ (Time of mother's signature)

\_\_\_\_\_ (Place of mother's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of father)

\_\_\_\_\_ (Address of father)

\_\_\_\_\_ (City of father)

\_\_\_\_\_ (State of father)

\_\_\_\_\_ (Country of father)

\_\_\_\_\_ (Date of father's signature)

\_\_\_\_\_ (Time of father's signature)

\_\_\_\_\_ (Place of father's signature)

\_\_\_\_\_ (Other)

\_\_\_\_\_ (Signature of registrar)

## 1. PLACE OF DEATH

County of: *Lemhi*  
City of: *Salmon*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

RECEIVED  
CERTIFICATE OF DEATH  
Registration District No. *41*  
Primary Registration District No. *2116*  
(STATISTICS)State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *35615*  
Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word.)

6. DATE OF BIRTH

*Oct Second 1921*  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many hrs.  
or *None*

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Idaho.*

10. NAME OF FATHER

*Walter Henry Lund*

11. BIRTHPLACE OF FATHER

(State or Country)

*Philsburg, Mont.*

12. MAIDEN NAME OF MOTHER

*Fanny Ella Hibbs*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Shoup, Idaho.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *10-10-1921**Chas Bellamy*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*October 2 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Still born* to \_\_\_\_\_ 19\_\_\_\_

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

*Persistent deeply proteinuria  
Instrumental delivery*

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

*C. D. Stratton*

M. D.

*10-10-1921* (Address) *Salmon Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

*Salmon, Ida*

DATE OF BURIAL

*10/3/1921*

20. UNDERTAKER

*W. B. Orlicher*

ADDRESS

*Salmon, Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

395-110-03K-419

PLACE OF BIRTH

County of Minidoka

City of Rupert

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Registration District No. 19

File No. \_\_\_\_\_

Primary Registration District No. 2015 Registered No. 161

Stillborn

Sex of Child <u>Male</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>Sept. 10</u> 19 <u>21</u> (Month) (Day) (Year)
--------------------------	---	-----	--------------------------	-------------------------	--

FULL NAME <u>Daniel Lindauer</u>	FATHER
RESIDENCE <u>Rupert</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Russia</u>	
OCCUPATION <u>Labour</u>	

FULL MAIDEN NAME <u>Emma Mail</u>	MOTHER
RESIDENCE <u>Rupert</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Russia</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth / Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 6:25 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. E. Ehlers  
M.D.  
(Physician or midwife)

Given names added from a supplemental report.

Address Rupert Ida.  
Filed Oct. 7 1921  
E. E. Ehlers  
Registrar

Registrar

Registrar

S94860



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

669-107-029-789

PLACE OF BIRTH RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of Zata OCT 31 1921

City of Vendrick BUREAU OF VITAL STATISTICS

Registration District No.

File No. **94875**

No. St.

Primary Registration District No.

Registered No.

Hospital

FULL NAME OF CHILD

Geo Richard Forest

Sex of Child

male

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and { Number  
in order  
of birth

Legiti  
mate?

yes

Date of Birth

8  
(Month)

7  
(Day)

21  
(Year)

FULL NAME

Mike Forest

FATHER

FULL MAIDEN NAME

Ida Phillips

MOTHER

RESIDENCE

Vendrick

RESIDENCE

Vendrick

COLOR

white

AGE AT LAST BIRTHDAY

34  
(Years)

COLOR

white

AGE AT LAST BIRTHDAY

33  
(Years)

BIRTHPLACE

Grand Forks N.D.

BIRTHPLACE

Wall Hotta N. D.

OCCUPATION

Lawyer

OCCUPATION

Nurse wife

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

Still Born, at 2 M.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. H. Kelly M.D.  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Vendrick, Ida,

Filed

Oct 10

19

R. F. Peppin

Registrar

Registrar

21



254-10.035-993

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No.

RECEIVED

CERTIFICATE OF BIRTH

County of Nevada

OCT 31 1921

City of Lemington

BUREAU OF VITAL

STATISTICS

Registration District No. 96

File No.

S 94879

No. 2705 - Main St.Primary Registration District No. 1009Registered No. 760

Hospital

FULL NAME OF CHILD

James Harry Knutson

Sex of Child

MaleTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti-  
mate?YesDate of  
BirthSept11921

(Month)

(Day)

(Year)

FULL NAME

Engle A. Knutson

FATHER

RESIDENCE

Lemington, Id.

COLOR

WhiteAGE AT LAST  
BIRTHDAY29

(Years)

BIRTHPLACE

Idaho

OCCUPATION

Bridge CarpenterFULL  
MAIDEN  
NAMELula Richardson

MOTHER

RESIDENCE

Lemington, Id.

COLOR

WhiteAGE AT LAST  
BIRTHDAY28

(Years)

BIRTHPLACE

Washington

OCCUPATION

HousewifeNumber of child of this mother, including present birth 3Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 8 P.M. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Paul W. JohnsonCheney, Wyo.

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

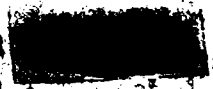
Oct-6 1921Susan E. Bruce

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

Registration District No. 96  
 County of *Blaine* Health Registration District No. 1009  
 City of *Leviston* St.)

If death occurs away from usual residence, give facts called for under special information.

## BUREAU OF VITAL STATISTICS

## 2. FULL NAME

*James Harry Kuntson*

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 35634  
 Registered No. 694

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male* *white* *Single*  
 (Write the word.)

## 6. DATE OF BIRTH

*Sept 12 1921*  
 (Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
 how many hrs. or min.?  
 Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
 (b) General nature of industry, business or establishment in which employed (or employer)

*Infant*

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*E. A. Kuntson*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Idaho*

## 12. MAIDEN NAME OF MOTHER

*Lulu Richardson*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) *E. A. Kuntson, Leviston, Idaho*

## 15. Filed

*Sept 22 1921*  
*Oct 8 1921*

*Ernest E. Bruce*  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Sept 1 1921*  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19  
 that I last saw him alive on 19  
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Still born baby. Had been dead 2 or 3 weeks when born.*

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Paul W. Johnson* M. D.

*9/1 1921* (Address) *Leviston, Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Leviston Cemetery* *Sept 2 1921*

## 20. UNDERTAKER

## ADDRESS

*Leviston, Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

168-213,035-528  
PLACE OF BIRTH

Form V. & No. 11-C-25m-9-8-17  
STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

County of NezPerce.....  
City of Lewiston, Ida......  
Registration District No. ....

No. 1504-Main.....St.

Primary Registration District No. ....

File No. ....

Registered No. ....

Hospital White.....

FULL NAME OF CHILD Stillborn Johnson.....

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> { Number in order of birth	Legiti-mate? <u>Yes</u>	Date of Birth <u>Sept. 13, 1921</u> (Month) (Day) (Year)
----------------------------	--	-------------------------	---

FULL NAME FATHER  
Galen Logan Johnson

RESIDENCE

NezPerce, Ida.

COLOR

White

AGE AT LAST BIRTHDAY

25

(Years)

BIRTHPLACE

Iowa

OCCUPATION

Farmer

FULL MAIDEN NAME MOTHER  
Isabell Ruth Eby

RESIDENCE

NezPerce, Ida.

COLOR

White

AGE AT LAST BIRTHDAY

25

(Years)

BIRTHPLACE

Mo.

OCCUPATION

House Wife

Number of child of this mother, including present birth 1..... Number of children of this mother now living, including present birth.....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn..... at 9:30 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn-child is one that neither breathes nor shows other evidence of life after birth.

(Signature) .....

Physician.....

(Physician or midwife)

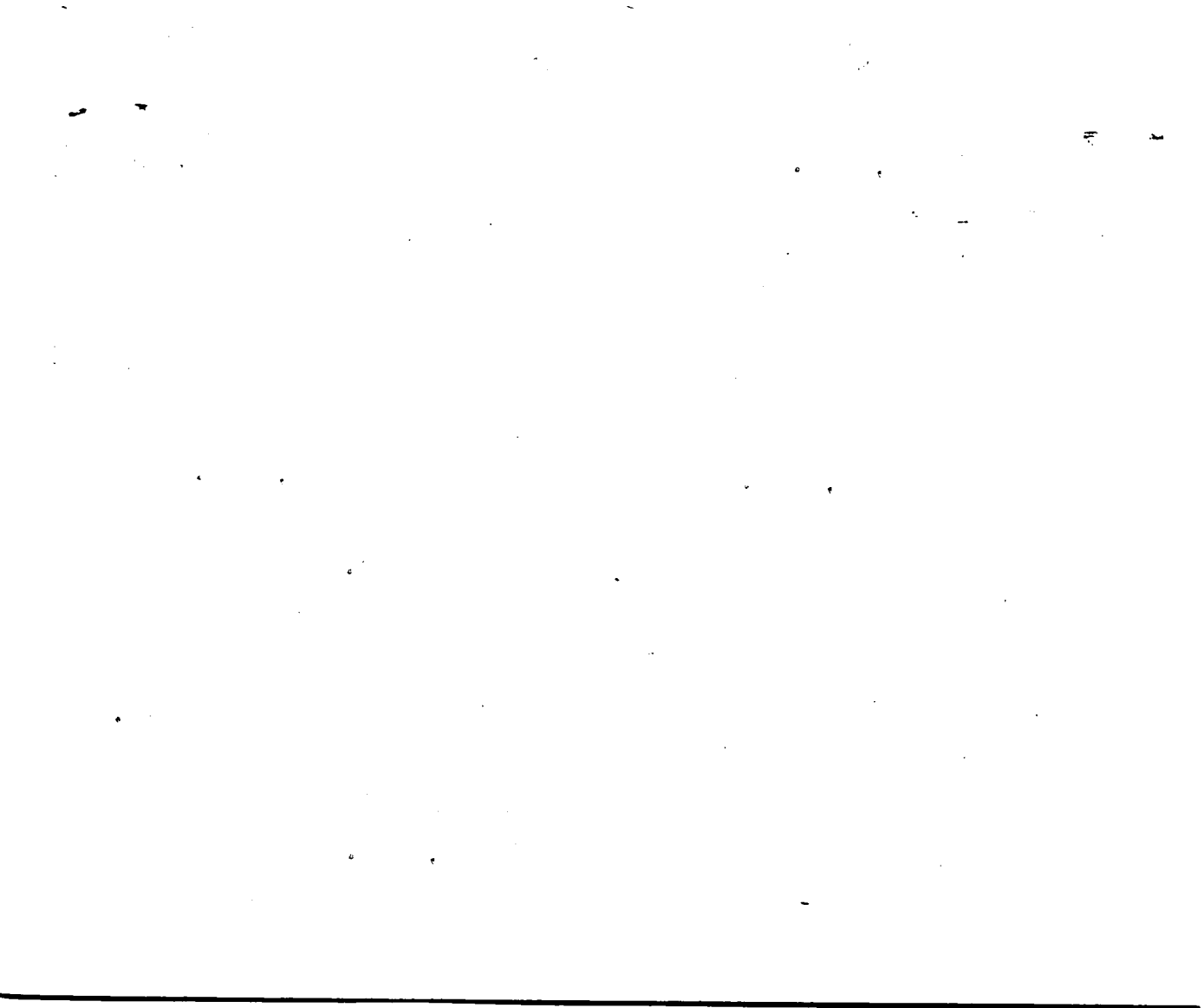
Given names added from a supplemental report.

Address Lewiston, Ida......

Filed Oct-6-21.....

Registrar

Registrar



FORM V. S. No. 5-25 M. 1-19.

## RECEIVED CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Lewiston District No. 96  
 City of Lewiston Registration District No. 1009  
 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Stillborn Johnson

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 35644  
 Registered No. 704

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female white Single  
 (Write the word)

## 6. DATE OF BIRTH

Sept 13 - 1921  
 (Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
 how many hrs. or min.?  
 Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer)

Stillborn

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Calvin S. Johnson

## 11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

## 12. MAIDEN NAME OF MOTHER

11

## 13. BIRTHPLACE OF MOTHER

(State or Country)

11

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Em Brown  
 (Address) Lewiston Ida

## 15.

Filed Oct - 8th 19 Swan E Bruce  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sept 13 1921  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY That I attended deceased from

Stillborn Sept 13 1921  
 that I last saw him alive on 19  
 and that death occurred on the date stated above, at M.

## The CAUSE OF DEATH\* was as follows:

Still born  
Premature - 7 mos  
 (Duration) Yrs. mos. ds.

## Contributory (Secondary)

(Duration) Yrs. mos. ds.  
 (Signed) E. L. White M. D.  
 (Address) Lewiston Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Lewiston, Idaho DATE OF BURIAL 9/15 1921

## 20. UNDERTAKER

UNDERTAKING CO ADDRESS Lewiston, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

236114-038-219

PLACE OF BIRTH

County of Payette

City of New Plymouth

No. 8 St.

Hospital \_\_\_\_\_

FULL NAME OF CHILD

RECEIVED  
OCT 31 1921  
STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
BUREAU OF VITAL STATISTICS  
Registration District No. 5

Form V. S. No. 11-C-25m-7-21-19

S 94970

File No. 2

Primary Registration District No. 2009

Registered No. 28

Infant Slone

Sex of Child <u>M</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimacy? <u>Yes</u>	Date of Birth <u>Sept 14</u> 19 <u>21</u> (Month) (Day) (Year)
-----------------------	-----------------------------------	-----------------------------------	------------------------	---

FATHER  
FULL NAME Rueben Slone  
RESIDENCE New Plymouth  
COLOR W AGE AT LAST BIRTHDAY 45  
(Years)

MOTHER  
FULL MAIDEN NAME Pearl Bartling  
RESIDENCE with husband  
COLOR W AGE AT LAST BIRTHDAY 34  
(Years)

BIRTHPLACE Idaho  
OCCUPATION farmer

BIRTHPLACE Idaho  
OCCUPATION Housewife

Number of child of this mother, including present birth 8 Number of children of this mother now living, including present birth 6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 3:30 a.m.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

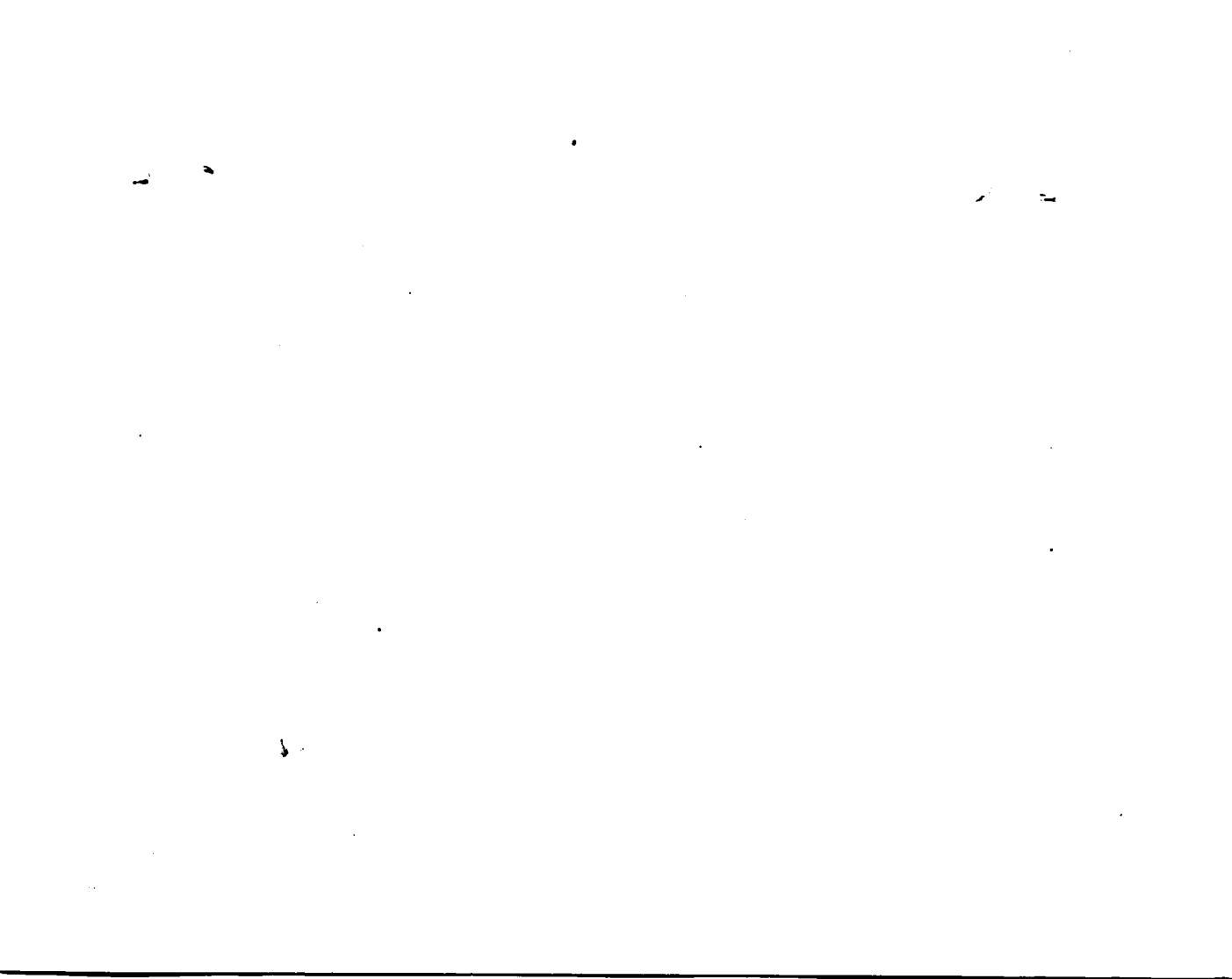
(Signature) Wm J. Drysdale M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address New Plymouth Ida

Filed Oct 21 1921 Wm J. Drysdale  
Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 35657

1. PLACE OF DEATH

RECEIVED

OCT 31 1921

Registration District No. 5

County of Payette

BUREAU OF VITAL STATISTICS

Primary Registration District No. 2009

City of

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Slave

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single  
(Write the word.)

6. DATE OF BIRTH

Sept 14 1921  
(Month) (Day) (Year)

7. AGE

Stillborn  
yrs. mos. ds.

IF LESS than 1 day  
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ruben Slave

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Pearl Bariling

13. BIRTHPLACE OF MOTHER

(State or Country)

Nbr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ruben Slave

(Address)

Nbr Plymouth

15.

Filed

Sept 15 1921

1921

W. J. Drysdale  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 14 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth 191., to 191., that I last saw h. alive on 191., and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

not known

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Drysdale M. D.

9-15-1921 (Address) Nbr Plymouth

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nbr Plymouth Ida

9-15-1921

20. UNDERTAKER

ADDRESS

Ruben Slave

Nbr Plymouth

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

133-202,042-319

PLACE OF BIRTH

County of Twin FallsCity of Twin FallsNo. 536-5th Ave WestHospital .....FULL NAME OF CHILD .....RECEIVED  
OCT 31 1921  
BUREAU OF VITAL  
STATISTICSSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-2-1-17

S 95096

Registration District No. 37File No. .....Primary Registration District No. 1085Registered No. .....

Sex of Child <u>Female</u>	Twin Triplet or other? <u>-</u>	and { Number in order of birth <u>-</u>	Legiti- mate? <u>yes</u>	Date of Birth <u>Oct 2</u> 19 <u>21</u> (Month) (Day) (Year)
----------------------------	---------------------------------------	---	-----------------------------	---

FULL NAME <u>M. C. Allen</u>	FATHER
RESIDENCE <u>Twin Falls</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>.....</u> (Years)

FULL MAIDEN NAME <u>Amy Larsen</u>	MOTHER
RESIDENCE <u>Twin Falls Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)

BIRTHPLACE <u>Escalante Utah</u>
OCCUPATION <u>Laborer for Twin Falls City</u>

BIRTHPLACE <u>Kenosha Wis</u>
OCCUPATION <u>House wife</u>

Number of child of this mother, including present birth 2nd Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn Oct 2, 1921 at 9:06 P.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. C. A. EganPhysician or midwife

Given names added from a supplemental report.

..... 10 .....Address Twin Falls..... 13 .....Filed Oct 10 1921 John H. Cooney Henn

Registrar

Registrar

CONFIDENTIAL

SECRET

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

9. PLACE OF DEATH

County of *Turn Falls*

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

# CERTIFICATE OF DEATH

Registration District No. *37*

Primary Registration District No. *1085*

BUREAU OF VITAL STATISTICS

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *35707*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19 *21*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. *10/1* alive on *10/1* and that death occurred on the date stated above, at *9 AM*.  
The CAUSE OF DEATH\* was as follows:

Contributory (Secondary)

(Signed)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



893-224042-236  
 PLACE OF BIRTH  
 County of *Twin Falls*  
 City of *Twin Falls*  
 No. .... St.  
 Hospital .....

RECEIVED  
 OCT 31 1921  
 BUREAU OF VITAL  
 STATISTICS

STATE OF IDAHO  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF BIRTH  
 S95097  
 Form V. S. No. 11-O-22m-9-5-17

Registration District No. .... 37  
 File No. ....  
 Primary Registration District No. .... 1085  
 Registered No. ....

FULL NAME OF CHILD .....

Sex of Child <i>female</i>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <i>yes</i>	Date of Birth <i>9 24 1921</i> (Month) (Day) (Year)
FULL NAME <i>William Parker Hices</i>	FATHER		FULL MAIDEN NAME <i>Bessie Lila Starry</i>	MOTHER
RESIDENCE <i>Twin Falls, Ida</i>	RESIDENCE		<i>Twin Falls, Ida</i>	
COLOR <i>white</i>	AGE AT LAST BIRTHDAY <i>30</i> (Years)	COLOR <i>white</i>	AGE AT LAST BIRTHDAY <i>22</i> (Years)	
BIRTHPLACE <i>S. Dak.</i>	BIRTHPLACE <i>Iowa</i>			
OCCUPATION <i>farmer</i>	OCCUPATION <i>House wife</i>			

Number of child of this mother, including present birth... 3 Number of children of this mother now living, including present birth... 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was *still born*, at *9 P.* M.  
 on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife (then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.)

(Signature) *C. D. Mearns*  
*Physician*  
 (Physician or midwife)

Given names added from a supplemental report.  
 ..... 18  
 Address .....  
 Filed *Oct 10 1921* *John Houghtlin*  
 Registrar

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF BIRTH

Registration District No. \_\_\_\_\_  
Date of Death \_\_\_\_\_  
Age at Death \_\_\_\_\_  
Sex \_\_\_\_\_  
Race \_\_\_\_\_  
Color \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Occupation \_\_\_\_\_  
Cause of Death \_\_\_\_\_  
Manner of Death \_\_\_\_\_  
Place of Death \_\_\_\_\_  
Signature of Registrar \_\_\_\_\_  
Signature of Physician \_\_\_\_\_  
Signature of Coroner \_\_\_\_\_  
Signature of Medical Examiner \_\_\_\_\_  
Signature of County Clerk \_\_\_\_\_  
Signature of State Registrar \_\_\_\_\_

DATE OF BIRTH	PLACE OF BIRTH	AGE AT DEATH	SEX	RACE	COLOR	MARITAL STATUS	OCCUPATION	CAUSE OF DEATH	MANNER OF DEATH	PLACE OF DEATH	SIGNATURE OF REGISTRAR	SIGNATURE OF PHYSICIAN	SIGNATURE OF CORONER	SIGNATURE OF MEDICAL EXAMINER	SIGNATURE OF COUNTY CLERK	SIGNATURE OF STATE REGISTRAR

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her

and that death occurred on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Signed)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death In the

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

249-415-041-883

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Leton

OCT 31 1921

CERTIFICATE OF BIRTH

City of Driggs

BUREAU OF VITAL  
STATISTICS

Registration District No. 77

File No. S95103

No. \_\_\_\_\_ St.

Primary Registration District No. 2176

Registered No. 37

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Still-born

Sex of Child <u>boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? <u>yes</u>	Date of Birth <u>9</u> <u>15</u> <u>1921</u> (Month) (Day) (Year)
-------------------------	---	-----	--------------------------------	-------------------------------	---

FATHER  
FULL NAME Francis W. Smith  
RESIDENCE Driggs Ida  
COLOR white  
AGE AT LAST BIRTHDAY 27 (Years)  
BIRTHPLACE Boston Soc.  
OCCUPATION Laborer

MOTHER  
FULL MAIDEN NAME May Hyblton  
RESIDENCE Driggs  
COLOR white  
AGE AT LAST BIRTHDAY 23 (Years)  
BIRTHPLACE Salt Lake Utah  
OCCUPATION mother

Number of child of this mother, including present birth \_\_\_\_\_ Number of children of this mother now living, including present birth \_\_\_\_\_

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

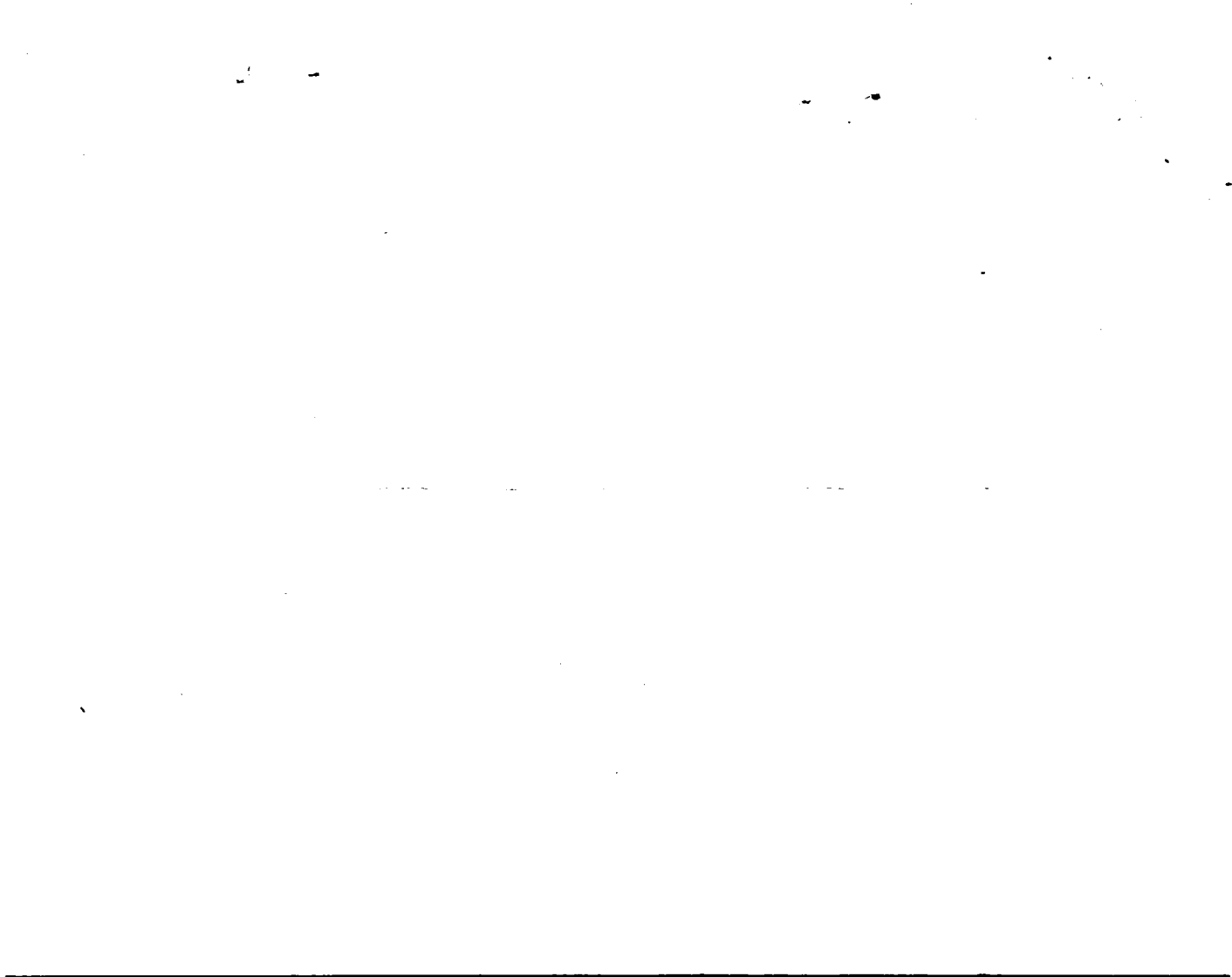
I hereby certify that I attended the birth of this child, who was stillborn at 6-20 P.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Emily J. Beesley  
midwife  
(Physician or midwife)

Given names added from a supplemental report.

Address Driggs Idaho  
Filed 9/23/1921 Martha Markin  
Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 35689  
Registered No. 18

1. PLACE OF DEATH  
County of Idaho  
City of Driggs  
Registration District No. 77  
Primary Registration District No. 2176  
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
(Write the word.)

6. DATE OF BIRTH  
September 15 - 1921  
(Month) (Day) (Year)

7. AGE  
Yrs. Mos. ds.  
IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).  
Infant

9. BIRTHPLACE  
(State or Country) Driggs, Idaho.

10. NAME OF FATHER  
Francis V. Smith

11. BIRTHPLACE OF FATHER  
(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER  
May Hilton

13. BIRTHPLACE OF MOTHER  
(State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) May H. Smith  
(Address) Driggs Idaho.

15. Filed Sept 20 - 1921 Martha Marker  
Local Registrar

16. DATE OF DEATH  
Unknown  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
19 to 19  
that I last saw him alive on 19  
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:  
Dead Fetus from 5 to 6 mo.  
Beginning miscarriage at time of birth.  
(Duration) Yrs. mos. ds.

Contributory (Secondary)  
(Duration) yrs. mos. ds.  
(Signed) J. H. Culbertson M. D.  
Sept 17, 1921 (Address) Driggs Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death yrs. mos. days. In the State yrs. mos. days.  
Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Driggs Idaho DATE OF BURIAL Sept 17, 1921

20. UNDERTAKER W. F. King ADDRESS Driggs, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

249-218-042-714  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Twin Falls **RECEIVED**  
City of Buhl **OCT 31 1921**  
No. 39 **BUREAU OF VITAL**  
St. 39 **Registration District No.**  
Hospital 2087 **Primary Registration District No.**  
**FULL NAME OF CHILD** Patricia Ann Burke **S 95131**  
(Certificate of no value without full name of child.)

<b>Sex of Child</b> <u>Girl</u>	<b>Twin Triplet or other?</b> <u>None</u> (To be answered only in event of plural births)	<b>and</b>	<b>Number in order of birth</b> <u>1</u>	<b>Legitimate?</b> <u>Yes</u>	<b>Date of birth</b> <u>9-18-1921</u> (Month) (Day) (Year)
---------------------------------	--	------------	--	-------------------------------	---

**What bactericidal solution was used in eyes?** none

**Number of child of this mother, including present birth** 1 **Number of child of this mother now living, including present birth** 0

**FATHER**  
**FULL NAME** Rollin Gleasure Burke  
**RESIDENCE** Buhl Ida  
**COLOR** wh **AGE AT LAST BIRTHDAY** 25  
(Years)  
**BIRTHPLACE** Neb.  
**OCCUPATION** Salesman

**MOTHER**  
**FULL MAIDEN NAME** Winifred May Padon  
**RESIDENCE** Buhl Id.  
**COLOR** wh **AGE AT LAST BIRTHDAY** 24  
(Years)  
**BIRTHPLACE** Neb.  
**OCCUPATION** Housewife

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\***

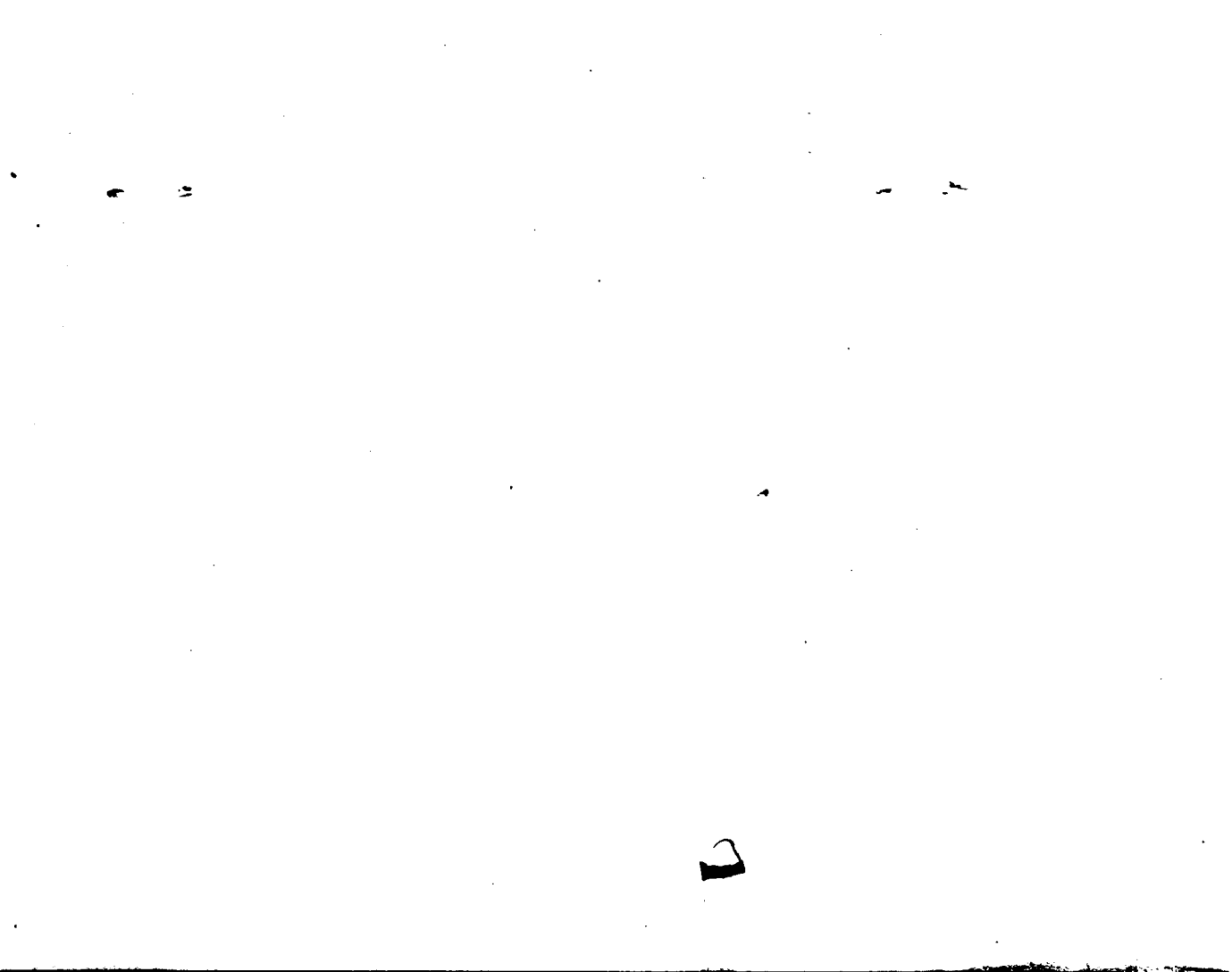
I hereby certify that I attended the birth of this child, who was still born at 11 a. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Geo. Jennings M. N.  
(Physician or midwife)

**Give names added from a supplemental report.**  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_  
**Registrar.**

**Address** Buhl  
**Filed** 10-1 **1921** J. H. Murphy  
**Registrar.**



## 1. PLACE OF DEATH

County of *Twin Falls*City of *" " " "*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED

## CERTIFICATE OF DEATH

Registration District No. *34*Primary Registration District No. *1086*No. *" " " "*

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *35697*Registered No. *" " " "*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Paericia Ann Burk*

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

(Write the word.)

6. DATE OF BIRTH *Sep. 18, 1921*

(Month)

(Day)

(Year)

7. AGE *0 Yrs. 0 Mos. 0 ds.*IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *Twin Falls Idaho*

(State or Country)

10. NAME OF FATHER *A. G. Burk*11. BIRTHPLACE OF FATHER *Hastings Neb.*

(State or Country)

12. MAIDEN NAME OF MOTHER *Wendred Burk*13. BIRTHPLACE OF MOTHER *York Neb.*

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. G. Burk*(Address) *Idaho*15. Filled *Sep. 20, 1921*Local Registrar *John F. Coughlin*

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sep. 18, 1921*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *9-18-1921* to *9-18-1921*that I last saw him alive on *19*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH\* was as follows:

*Still born - death probably due to instrument pressure or prolonged etherization. W. 9 mos.*

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo. Jennings*

M. D.

*9-18-21* (Address) *Bull Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Twin Falls Idaho*DATE OF BURIAL *24/19 1921*20. UNDERTAKER *J. E. Whit*ADDRESS *Twin Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

313-130-08-497  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 95175

County of Ada

City of Boise

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Hospital St. Luke's

Primary Registration District No. 1004

Registered No. 475

FULL NAME OF CHILD

William Riley Tallent

(Certificate of no value without full name of child.)

Sex of  
Child

Male

Twin  
Triplet  
or other?

{ and }

Number  
in order  
of birth

Legiti-  
mate?

Yes

Date of  
birth

Oct. 30, 1921

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 0

FULL  
NAME

FATHER

Jep J. Tallent

FULL  
MAIDEN  
NAME

MOTHER

Amya Ray Dixon

RESIDENCE

501 State St., Boise, Idaho

RESIDENCE

501 State St., Boise, Idaho

COLOR

White

AGE AT LAST  
BIRTHDAY

27

(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY

25

(Years)

BIRTHPLACE

Tennessee

BIRTHPLACE

Tennessee

OCCUPATION

Clark

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn  
on the date above stated.

at 8:45 p. M.  
(Born alive or stillborn)

{ \*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth. }

(Signature)

J. M. Taylor  
M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

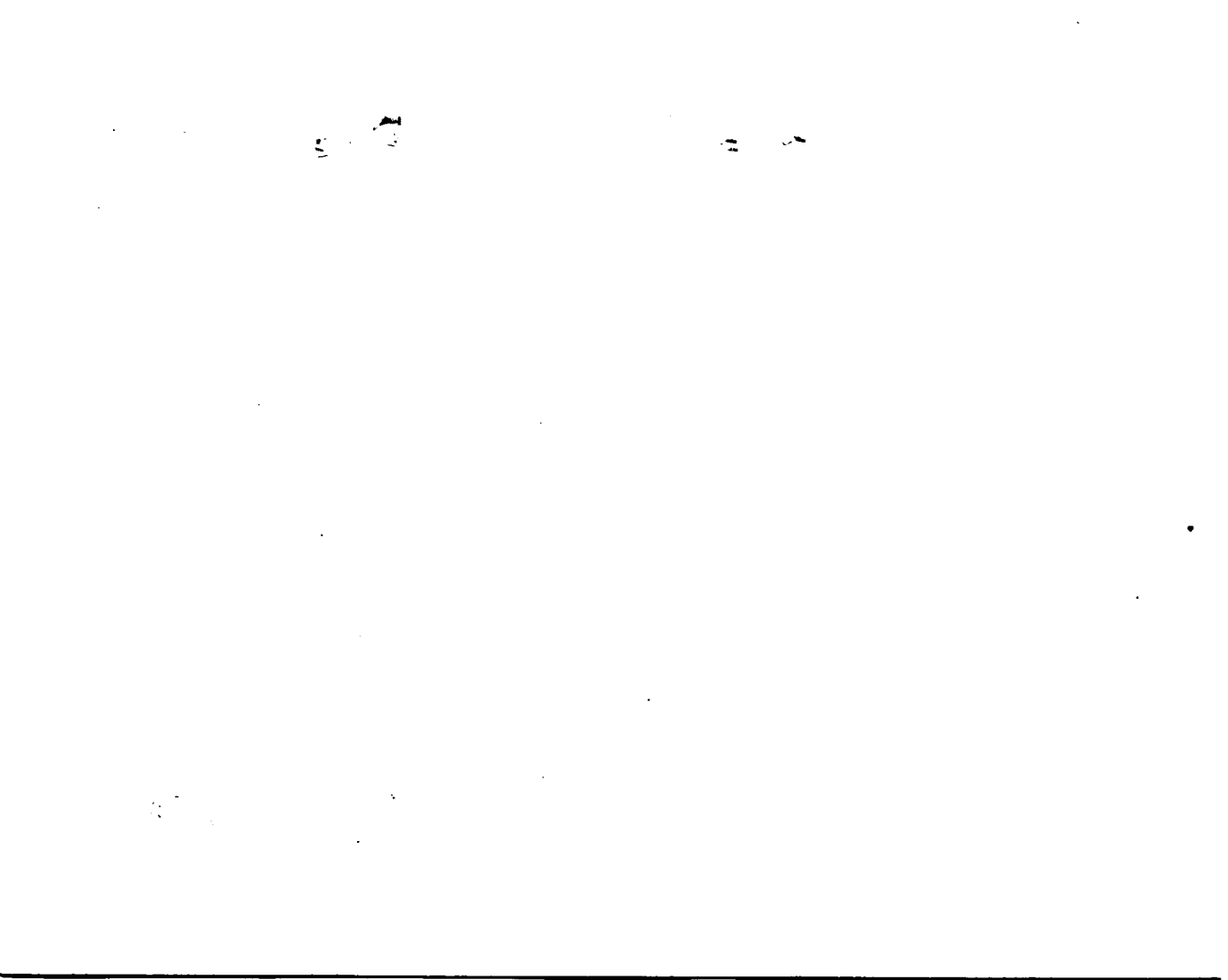
Boise, Idaho

Filed

Nov 9, 1921

Registrar

Registrar



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. **35721**  
Registered No. **218**

1. PLACE OF DEATH **Boise**  
County of **Boise**  
City of **Boise**  
Registration District No. **St. Luke's Hospital**  
Registrar Registration District No. **St. Luke's Hospital**  
(No. **St. Luke's Hospital** St.)  
If death occurs away from usual residence, give facts called for under special information.  
2. FULL NAME **William Riley Tallent**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **m.** 4. COLOR OR RACE **white.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**  
6. DATE OF BIRTH **Oct 30 1921**  
(Month) (Day) (Year)  
7. AGE **1** yrs. **10** mos. **21** ds.  
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION **none**  
(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE **Idaho**  
(State or Country)

10. NAME OF FATHER **Jep J. Tallent**

11. BIRTHPLACE OF FATHER **Penn.**  
(State or Country)

12. MAIDEN NAME OF MOTHER **Anne R. Dixon**

13. BIRTHPLACE OF MOTHER **Penn.**  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **Jep Tallent**  
(Address) **11201 N. S. Boise, Ida.**

15. Filed **Nov 1 - 1921**  
Local Registrar **R. H. Pratt**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 30 1921**  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 30<sup>th</sup> 1921** to **Oct 30<sup>th</sup> 1921**, that I last saw him **alive on** **19** and that death occurred on the date stated above, at **8:45 P. M.**  
The CAUSE OF DEATH\* was as follows:

**Stillborn - Ruptured due to pressure on cord during labor as cord was a very short. Marked by erosion of head at birth showing that heart was present while head engaged. No heart beat when born.**  
(Signed) **J. M. Taylor** M. D.  
**10/31 1921** (Address) **Boise Idaho**

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death **0** yrs. **0** mos. **0** days. In the State **0** yrs. **0** mos. **0** days.

Where was disease contracted if not at place of death?  
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Morris Hill Cem.** DATE OF BURIAL **Oct 31 1921**

20. UNDERTAKER **Summers & Co.** ADDRESS **Boise Idaho**

1  
9  
5  
8  
1

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

155-123,601-219  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S95204

County of Ada

City of Boise

No. St. Luke St.

Registration District No. 7

File No. S95204

Hospital

Primary Registration District No. 1004

Registered No. 504

FULL NAME OF CHILD

Infant Avery

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>1</u> } and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Nov 23</u> 192 <u>1</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What hysterical solution was used in eyes? none Still Born

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER  
FULL NAME Charles W. Avery

MOTHER  
FULL MAIDEN NAME Abby Bails

RESIDENCE 617 1/2 S. 13th St Boise

RESIDENCE 617 1/2 S. 13th Boise

COLOR white AGE AT LAST BIRTHDAY 30 (Years)

COLOR white AGE AT LAST BIRTHDAY 25 (Years)

BIRTHPLACE Iowa

BIRTHPLACE Kansas

OCCUPATION Truck Driver

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still Born at 1:30 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) T. M. Braxton

M.D.  
(Physician or midwife)

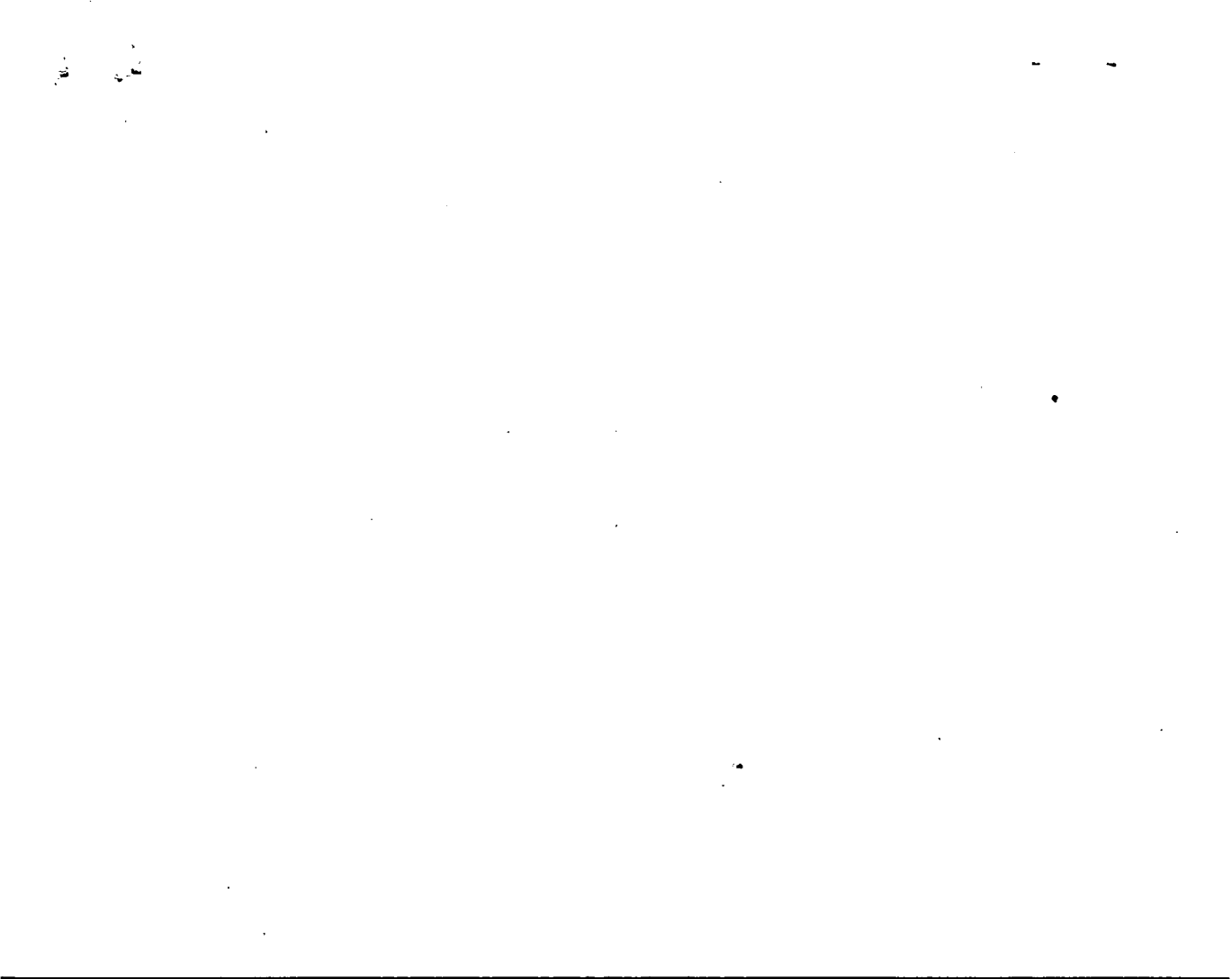
Give names added from a supplemental report.

Address Carpenter B. Boise Idaho

Filed Nov 21 1921 R. H. Pratt

Registrar.

Registrar.



## 1. PLACE OF DEATH

County of Ada  
City of Boise

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Avery

## CERTIFICATE OF DEATH

Registration District No. ....

Registration District No. ....

(No. 110 E Barnock St.)State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 35740Registered No. 344

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDM White Single  
(Write the word.)

## 6. DATE OF BIRTH

Nov. 23 1921  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many.....hrs.  
or.....min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. P. W. Wemy(Address) 617 E. 813th St.

## 15.

Filed Nov 25 1921R. H. Pratt  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Nov 23 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Nov 23 1921 to Nov 23 1921that I last saw h. Still Born 19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory Large child, Version  
(Secondary) and Extraction

(Duration) yrs. mos. ds.

(Signed) J. N. Brappan M. D.(Address) Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs. mos. days In the State.....yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery Nov. 26 1921

## 20. UNDERTAKER ADDRESS

Summers & White Boise Id.

2  
1891  
A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

253253  
PLACE OF BIRTH  
00-366 Ada  
County of  
City of Kuna  
No. St. BUREAU OF VITAL STATISTICS  
Hospital Primary Registration District No. 2202  
FULL NAME OF CHILD Ona Mae Bell  
(Certificate of no value without full name of child.)

RECEIVED  
NOV 30 1921  
BUREAU OF VITAL STATISTICS  
WELFARE  
BUREAU OF VITAL STATISTICS  
File No. 7-7-3  
Registered No. 115  
S95215

Sex of Child female	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth }	Legitimate? yes	Date of birth 11 3 1921 (Month) (Day) (Year)
---------------------	--	----------------------------------	-----------------	---

What bactericidal solution was used in eyes? .....

Number of child of this mother, including present birth 1	Number of children of this mother now living, including present birth 0
---	---

FULL NAME FATHER William A. Bell	FULL MAIDEN NAME MOTHER Agnes Vida Townsend
RESIDENCE Kuna Idaho	RESIDENCE Kuna Idaho
COLOR white	COLOR white
AGE AT LAST BIRTHDAY 40 (Years)	AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Missouri	BIRTHPLACE Nebraska
OCCUPATION Farmer	OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 5:30 a.m. on the date above stated. (Born alive or stillborn)

{ \*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Signature) H. F. Neal  
M.D.  
(Physician or midwife)

Give names added from a supplemental report.  
Address Meridian Idaho  
Filed 11-30 1921 W. H. Stevens  
Registrar.



2

2

2

2

## CERTIFICATE OF DEATH

35756 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Ada Registration District No. 174  
City of Prima Registration District No. 2202 St.)File No. 38Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

(Infant)Bell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Sex Female Color W Single, Married, Widowed or Divorced Single  
(Write the word.)

## 6. DATE OF BIRTH

11 - 3 1921  
(Month) (Day) (Year)

## 7. AGE

If LESS than 1 day how many hrs. or min.?  
Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Kuna Idaho

## 10. NAME OF FATHER

H. A. Bell

## 11. BIRTHPLACE OF FATHER

(State or Country) Mo

## 12. MAIDEN NAME OF MOTHER

Agnes Townsend

## 13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. M. Bell

(Address)

Kuna Idaho

## 15.

Filed 11 - 8 1921 W. E. Stevens  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

11 - 3 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

1921 to 11 - 3 1921that I last saw him alive on 11 - 3 1921and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. F. Hester

M. D.

11 - 3 1921(Address) Meridian Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Kuna Cemetery 11/3 1921

## 20. UNDERTAKER

## ADDRESS

Schreiber & Widengaden Boise

189-6

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

394-1041-003-791  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

95244

County of Bannock

City of Payson

No. 755 N 7 Ave St.

Hospital Payson

Registration District No. 28

File No. 75

Primary Registration District No. 2161

Registered No. 4078

FULL NAME OF CHILD Still birth

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>11/4</u> 192 <u>1</u> (Month) (Day) (Year)
-----------------------	--	------------------------	--

What bacteriocidal solution was used in eyes? 5

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 0

FATHER  
FULL NAME Augustina Cimarelli  
RESIDENCE Payson

MOTHER  
FULL MAIDEN NAME Madolina Bianchetti  
RESIDENCE same

COLOR W AGE AT LAST BIRTHDAY 44 (Years)

COLOR W AGE AT LAST BIRTHDAY 25 (Years)

BIRTHPLACE Italy

BIRTHPLACE Italy

OCCUPATION Farmer

OCCUPATION husb

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was dead at 8 P. M. on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) [Signature]

(Physician or midwife)

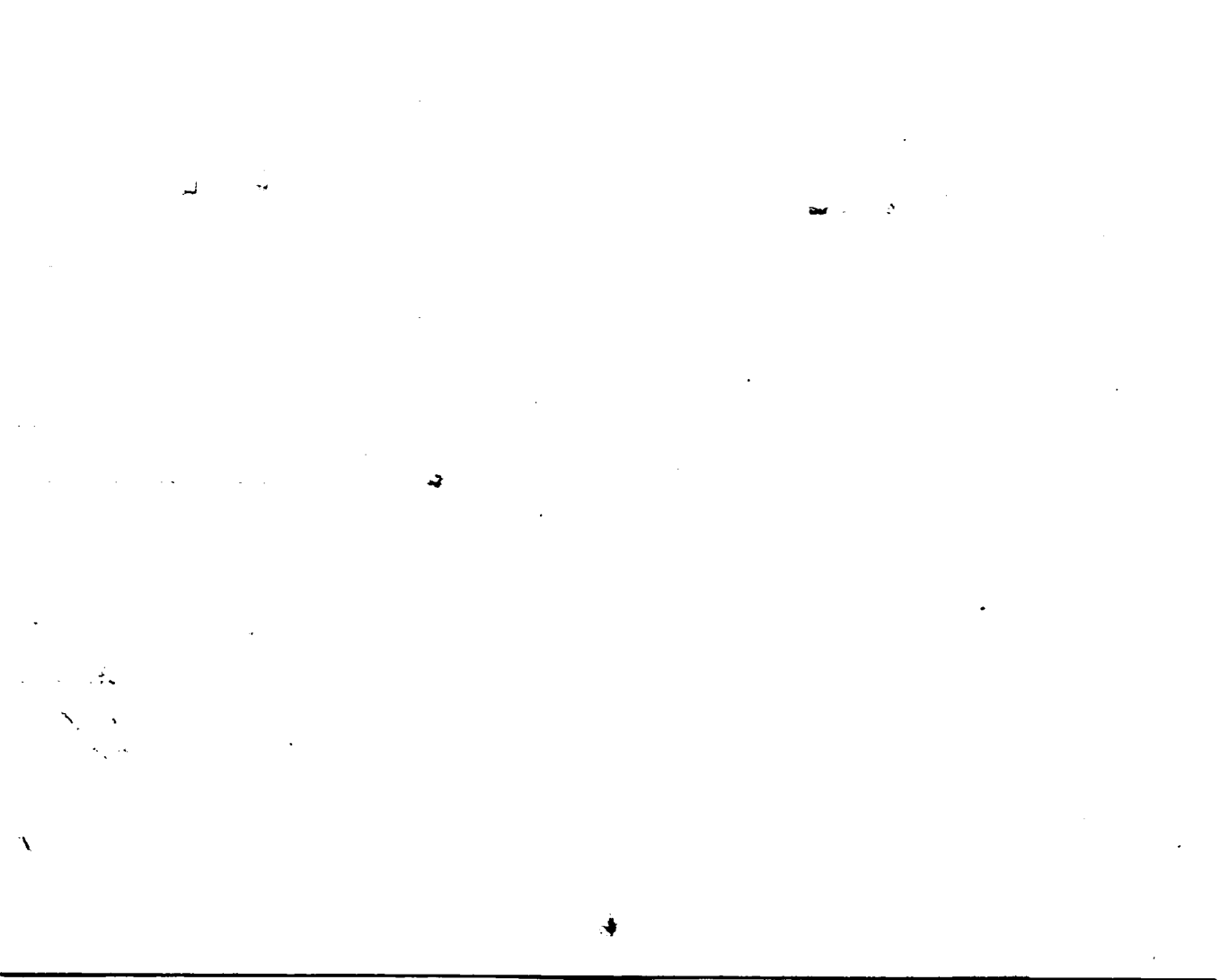
Give names added from a supplemental report.

Address Payson, Ida

Filed 12/1, 1921

Registrar.

Registrar.



## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

## 11. BIRTHPLACE OF FATHER

(State or Country)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15.

Filed

## RECEIVED CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

STATISTICS

35778 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

(Month)

(Day)

19. (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

11/4 1921, to 11/4 1921,  
that I last saw him alive on 11/4 1921,  
and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH\* was as follows:

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

11/5 1921 (Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

## 20. UNDERTAKER

## ADDRESS

7-481  
A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

466218-006-157  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S95330

County of Bingham

City of Blackfoot

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 121

File No. S95330

Hospital Blackfoot, Ida

Primary Registration District No. 1007

Registered No. 312

FULL NAME OF CHILD

No Name Moody  
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	<u>1</u> and <u>1</u> Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Nov 18</u> 192 <u>1</u> (Month) (Day) (Year)
----------------------------	---	---	-----------------------------	---

What bactericidal solution was used in eyes? Stillborn

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER FULL NAME <u>Ray F. Moody</u>	MOTHER FULL MAIDEN NAME <u>Grace Angell</u>
RESIDENCE <u>Pringle Ida</u>	RESIDENCE <u>Pringle</u>
COLOR <u>White</u>	COLOR <u>White</u>
AGE AT LAST BIRTHDAY <u>43</u> (Years)	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Illinois</u>	BIRTHPLACE <u>Wisconsin</u>
OCCUPATION <u>Farming</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

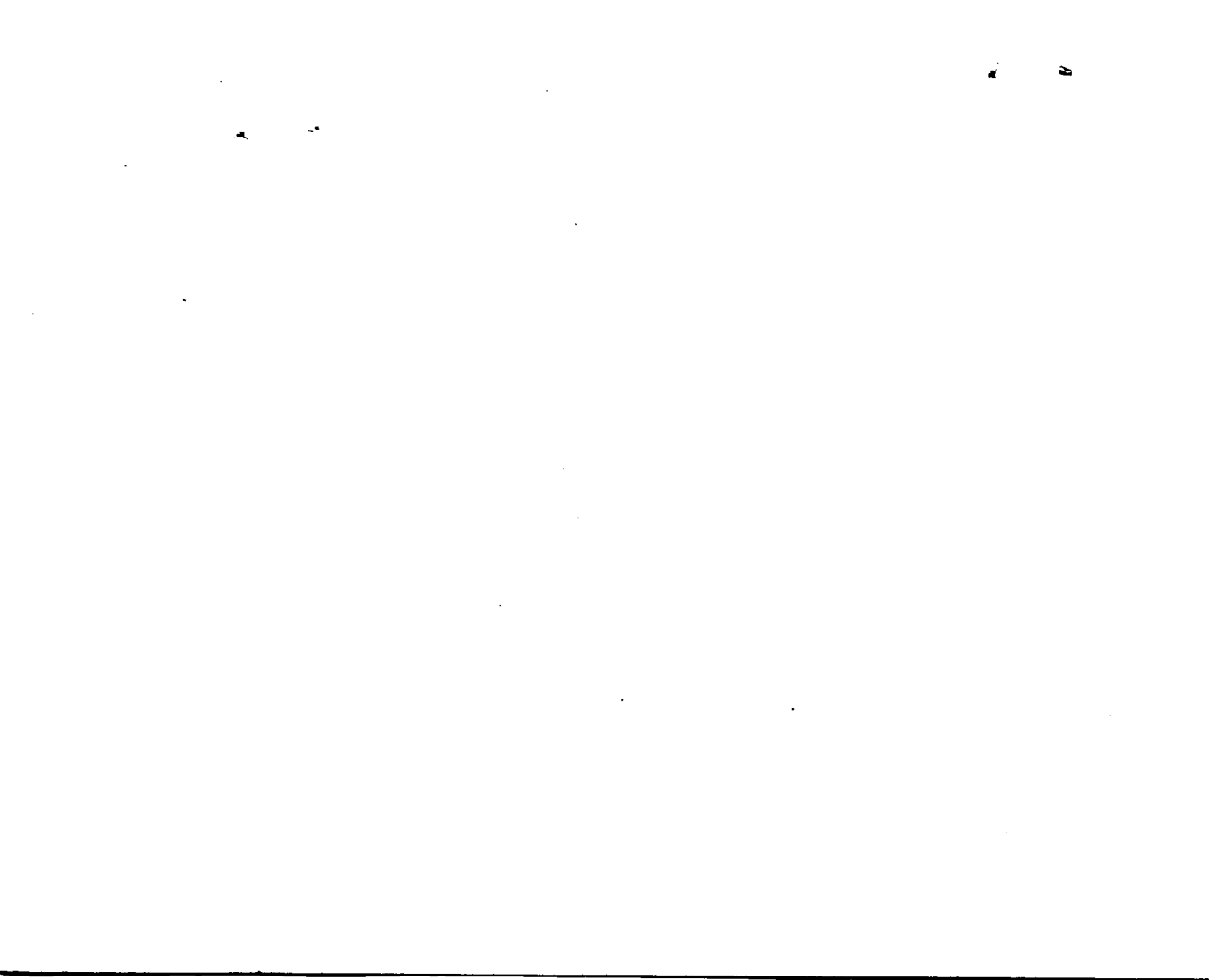
I hereby certify that I attended the birth of this child, who was stillborn at 1:00 P M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W W Beck  
Physician  
(Physician or midwife)

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_  
Registrar.

Address Blackfoot, Ida  
Filed Dec 3 1921 W W Beck Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH

1. PLACE OF DEATH  
County of Bingham Registration District No. 121  
City of Blackfoot Registration District No. 2194 (No. 2194 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No name Moody

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 36752  
Registered No. 36752

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single  
(Write the word.)

6. DATE OF BIRTH. Nov 18 1921  
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day how many.....hrs. or.....min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

Ray F. Moody

## 11. BIRTHPLACE OF FATHER

(State or Country) Illinois

## 12. MAIDEN NAME OF MOTHER

Grace Ingell

## 13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ray F. Moody(Address) Ingell, Ida

## 15.

Filed Nov. 18 1921

Mr. Hallie E. Tate  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Stillborn Nov 18 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1921 to Nov 18 1921, that I last saw her alive on Stillborn 1921 and that death occurred on the date stated above, at ..... M. The CAUSE OF DEATH\* was as follows:

Stillborn at 7th month  
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Beck M. D.

11/18/1921 (Address) Blackfoot, Ida.

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

Moody Farm Pangu DATE OF BURIAL Nov 19 1921

ED UNDERAKER ADDRESS Blackfoot, Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 5 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF BIRTH

362-127-005-391  
PLACE OF BIRTH

County of... Benewah

City of... St. Maries

No. .... St.

Hospital .....

FULL NAME OF CHILD ..... none

RECEIVED

DEC 10 1921

BUREAU OF VITAL  
STATISTICSRegistration District No. .... 32  
Primary Registration District No. .... 2049

File No. .... S95308

Registered No. .... 116

Sex of Child	male	Twin Triplet or other?		and	Number in order of birth	Legitimate?	yes	Date of Birth	Nov 29 1921
		(To be answered only in event of plural births)						(Month)	(Day)

FATHER  
FULL NAME Aleck Coburn

RESIDENCE

St. Maries

COLOR

white

AGE AT LAST BIRTHDAY

33

(Years)

BIRTHPLACE

Broadview, Saskatchewan

OCCUPATION

Laborer

MOTHER  
FULL MAIDEN NAME

Marjory Cravath

RESIDENCE

St. Maries

COLOR

white

AGE AT LAST BIRTHDAY

24

(Years)

BIRTHPLACE

Audubon, Minn.

OCCUPATION

Housewife

Number of child of this mother, including present birth .... 3 ... Number of children of this mother now living, including present birth .... 3 ...

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was .... Stillborn ..... at ..... 9 A.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) .... C. B. Smith M.D.

Physician

(Physician or midwife)

Given names added from a supplemental report.

Address .....

Filed Dec 9 1921

Registrar

Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of each, stated.

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

10

243/29.009.751

## PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S

County of BonnerSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
RECEIVED  
DEC 1 1921  
CERTIFICATE OF BIRTH

95476

City of NewportBUREAU OF VITAL  
STATISTICS  
Registration District No. 85File No. 3

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 2185 Registered No. 113

Hospital \_\_\_\_\_

FULL NAME OF CHILD Leonard Jacob Butler

Sex of Child <u>Male</u>	Twin Triplet <u>One</u> and <u>3rd</u> in order of birth (To be answered only in event of plural births)	Legitt mate? <u>yes</u>	Date of Birth <u>Oct 29</u> 19 <u>21</u> (Month) (Day) (Year)
--------------------------	---	-------------------------	--

FATHER  
FULL NAME Eugene Melvin Butler  
RESIDENCE Newport Ida.  
COLOR white  
AGE AT LAST BIRTHDAY 30 (Years)  
BIRTHPLACE Spokane Wash.  
OCCUPATION Lumberman

MOTHER  
FULL MAIDEN NAME William Mary Seandreau  
RESIDENCE Newport Ida.  
COLOR white  
AGE AT LAST BIRTHDAY 30 (Years)  
BIRTHPLACE Twain Lakes Ida.  
OCCUPATION House wife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Oct. 29, 1921 at 12:30 P.M.  
on the date above stated. (Delivered or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. W. S. Sandwick(Physician or midwife)

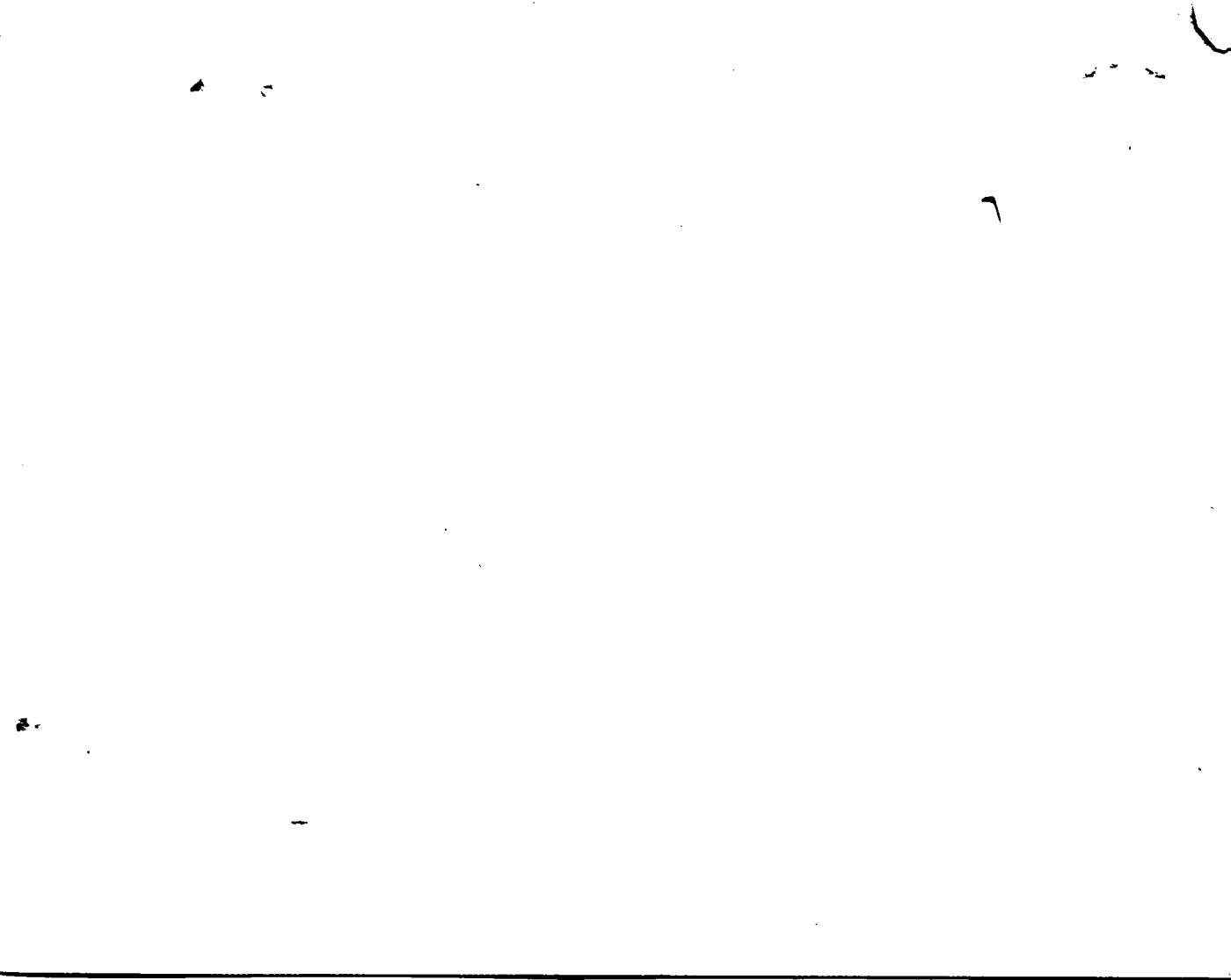
Given names added from a supplemental report.

19

Address Newport Wash.Filed Dec 1 1921

Registrar

Registrar C. T. Getchell



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

35866

RECEIVED  
Washington State Board of Health  
DEC 1 1921

PLACE OF DEATH  
County of Bonner  
City or Town of Newport  
Registration Dist. No. 85 No. 2185  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Record No. 54  
Registered No. 857

2. FULL NAME Baby Leonard Jacob Butler

(a) Residence No. \_\_\_\_\_ St.;  
(Usual place of abode)  
(b) If non-resident, give city or town, and state \_\_\_\_\_  
(c) How long in  
Registration Dist. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.; how long in U. S. if of foreign birth \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Personal and Statistical Particulars			Medical Certificate of Death		
3. Sex <u>Male</u>	4. Color or Race <u>White</u>	5. Single, Married, Widowed or Divorced (Write the word) <u>Single</u>	16. Date of death <u>Stillborn</u> (Month) (Day) (Year)		
6. (a) If married, widowed, or divorced: Husband of _____ or Wife of <u>Baby</u>			17. I HEREBY CERTIFY, That I attended deceased from <u>Oct 28</u> , 1921, to <u>Oct 29</u> , 1921, that I last saw h. _____ alive on _____, 1921, and that death occurred on the date stated above, at _____ m. (State the disease causing death, or, in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL). The CAUSE OF DEATH was as follows: <u>Stillborn</u> READ DETAILS ON OTHER SIDE		
7. Age <u>Stillborn</u> (Month) (Day) (Year) _____ yrs. _____ mos. _____ ds. _____ hrs. _____ or min.			(Primary) (See 1 and 3 other side) <u>Stillborn</u> (Duration) _____ yrs. _____ mos. _____ ds.		
8. Occupation of deceased: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Baby</u> (c) Name of employer _____			CONTRIBUTORY (Secondary) (See 2 other side) (Duration) _____ yrs. _____ mos. _____ ds.		
9. Birthplace (City or town) <u>Newport</u> (State or Country) <u>Idaho</u>			18. Where was disease contracted if not at the place of death? (a) Did an operation precede death? _____ Date of _____ (b) Was there an autopsy? _____ (c) What test confirmed diagnosis? (Signed) <u>Dr. M. D. Davis</u> M. D. <u>Oct 29, 1921</u> Address <u>Newport</u>		
PARENTS	10. Name of Father <u>Eugene Melvin Butler</u>		19. Place of Burial, Cremation or Removal <u>Newport</u>		
	11. Birthplace of Father (City or town) (State or Country) <u>Spokane, Wash.</u>		Date of Burial <u>Oct 29, 1921</u>		
	12. Maiden name of Mother <u>William Mary Gaudin</u>		20. Undertaker <u>Wm Davis Newport Wash</u>		
	13. Birthplace of Mother (City or town) (State or Country) <u>Newport, Idaho</u>		Address <u>Newport</u>		
14. Informant <u>Mrs E. M. Butler (mother)</u> Address <u>Newport</u>					
15. Filed <u>Dec 1</u> , 1921 Registrar.					

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions.  
(Insert numbers of unanswered questions)

(Signature of Undertaker)

# STATEMENT OF CAUSE OF DEATH

The attention of all persons authorized by law to sign death certificates is courteously directed to the following synopsis regarding said DEATH CERTIFICATES:

Moreover, please permit us to say that these are the laws of the State of Washington, and not the vagaries or personal idiosyncrasies of the State Commissioner of Health. The law makes it incumbent upon the State Board of Health to secure this information and provides a penalty for our failure to do so; it also makes it obligatory upon you to furnish, without delay, accurate and complete answers to all relevant questions and prescribes a penalty for your not complying with the law.

- (1) Name first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation). The contributory (secondary or intercurrent) affection need not be stated unless important.  
Example: Measles (disease causing death)—29 ds; Bronchopneumonia (secondary)—10 ds.
- (2) For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely.  
Examples: Accidental drowning; revolver wound of head—homicide; poisoned by carbolic acid—probably suicide.  
The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."
- (3) When surgery was done, state cause for which surgical interference was undertaken.
- (4) Additional information will be required on certificates giving any of the following diseases, without explanation, as the sole cause of death:

- Abortion, or miscarriage (State whether accidental, criminal, induced, etc.).  
Accident (State detail. Ex: Crushed by falling building; fell from a height; kicked by a horse; automobile accident, etc.) Give anatomical location of injury.
  - Burns (State explosion gasoline; conflagration; molten metal, etc.). (Indicate if burning building.)
  - Cancer (State organ or part first affected by cancer).
  - Childbirth (State causes of death i. e. Puerperal septicaemia, Puerperal peritonitis, etc.).
  - Convulsions (State cause).
  - Erysipelas (State cause).
  - Hemorrhage (Name the disease causing the death. In the course of which the hemorrhage was an incident).
  - Meningitis (Quality). Example: Cerebrospinal fever the only definite synonym is Epidemic cerebrospinal meningitis).
  - Pneumonia (State Lobar, etc.; If bronchopneumonia, state whether this was primary cause; If sequel or complication of some other condition state that condition).
  - Senility (Term undesirable, not acceptable. Set out definite disease causing death).
- (5) Never report a mere symptom or terminal condition, such as:
 

Asthma	Debility	Gastritis	Phlebitis	Tetanus
Cebulitis	Dropsy	Heart Failure	Pyæmia	Tuberculosis
Cellulitis	Exhaustion	Necrosis	Septicaemia	Typhemia
Coma	Gangrene	Peritonitis	Shock	Violence
- and expect to "get by" with it.
- Now, Doctor, if this certificate is returned because you overlooked an important detail, be a "Sport"—smile cheerfully—just as though you liked it—and furnish the information requested.

## TO THE UNDERTAKER

**STATEMENT OF OCCUPATION:** Precise statement of occupation is very important. The question applies to each and every person, irrespective of age.

- (a) **STATE:**
  - (1) Kind of work  
Nature of the industry in which such work is performed (or employer)
  - (2) If retired state last occupation:

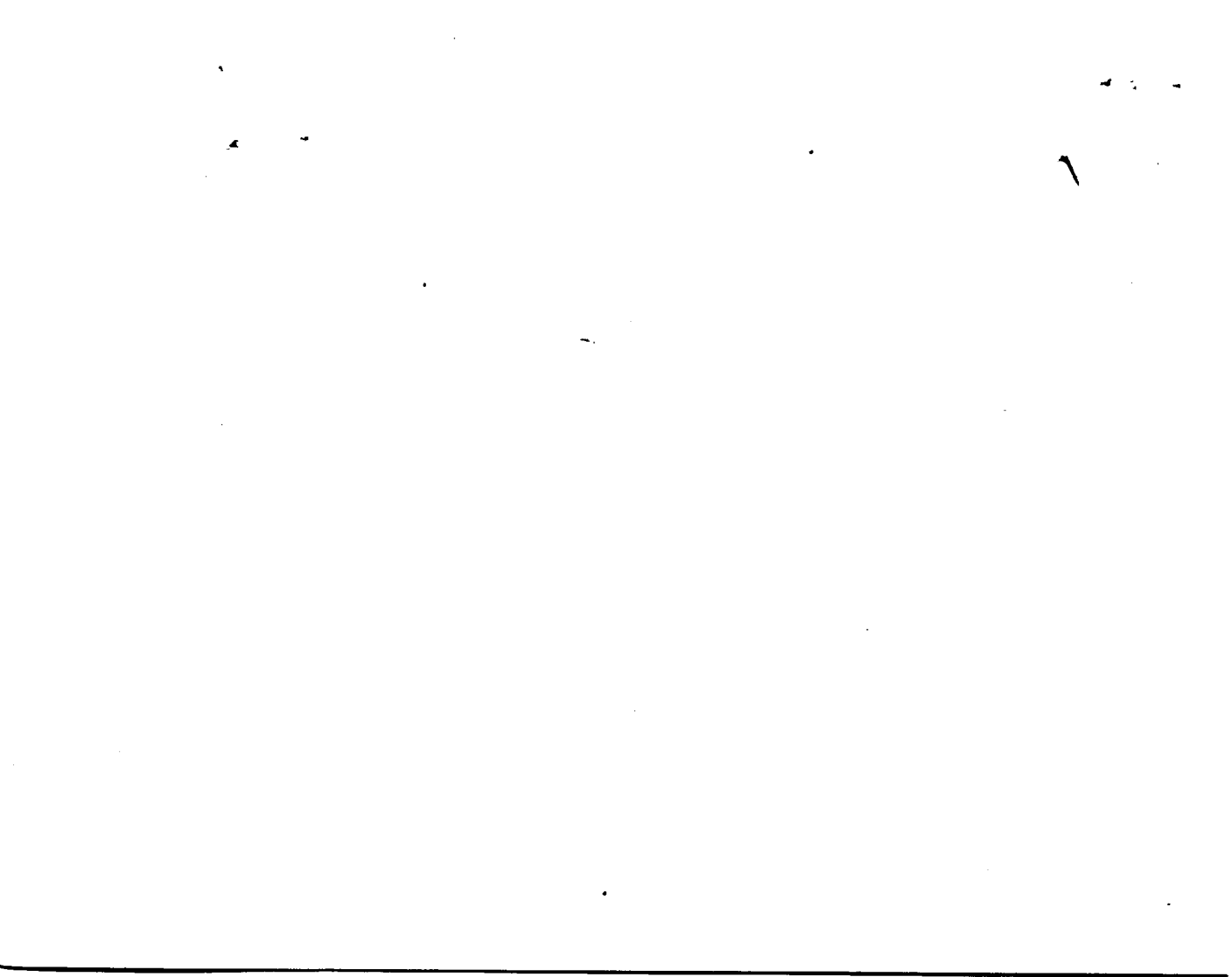
**EXAMPLE:** (1) Salesman (city or traveling)  
(2) Wholesale house (McClintock-Trunk Co.—Groceries)

- (b) If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness.
- (c) If no occupation whatever, write NONE.
- (d) Women at home (engaged in no outside field) may be entered: Housewife, Housework, At Home.
- (e) Persons engaged in domestic service for wages, report as: Servant, Cook, Housemaid, etc.
- (f) Children (not employed) should be entered as: At school, or At home.

**CAUTION:** Never return "Laborer," "Engineer," "Manager," "Dealer," etc., without more precise specification, as "Day Laborer," "Laborer—Coal mine," "Locomotive Engineer," "Civil Engineer," etc.

7-631







MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH			RECEIVED Washington State Board of Health			35865 2		
County of <u>Bonner</u>			BUREAU OF VITAL STATISTICS			Record No. ....		
City or Town of <u>Newport</u>			CERTIFICATE OF DEATH			Registered No. <u>57</u>		
Registration Dist No. <u>8</u>			No. <u>2183</u>			(If death occurred in a hospital or institution, give its NAME, instead of street and number)		
2. FULL NAME <u>Baby Martin (Twin #2)</u>								
(a) Residence No. .... St.; (Usual place of abode)								
(b) If non-resident, give city or town, and state .....								
(c) How long in Registration Dist. .... yrs. .... mos. .... ds.; how long in U. S. if of foreign birth .... yrs. .... mos. .... ds.								
Personal and Statistical Particulars					Medical Certificate of Death			
3. Sex <u>Male</u>	4. Color or Race <u>White</u>	5. Single, Married, Widowed or Divorced (Write the word) <u>Single Baby</u>			16. Date of death <u>Still born</u> (Month) (Day) (Year)			
6. (a) If married, widowed, or divorced Husband of ..... or Wife of <u>Baby</u>					17. I HEREBY CERTIFY, That I attended deceased from <u>10-13</u> , 1921, to ..... 1921 that I last saw h. .... alive on ..... 1921			
7. Age <u>Stillborn</u> (Month) (Day) (Year) If less than one day yrs. .... mos. .... ds. .... hrs. .... or min.					and that death occurred on the date stated above, at ..... m. (State the disease causing death, or, in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL). The CAUSE OF DEATH was as follows:			
8. Occupation of deceased: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Baby</u>					READ DETAILS ON OTHER SIDE (Primary) <u>Not known</u> (See 1 and 3 other side)			
(c) Name of employer .....					(Duration) .... yrs. .... mos. .... ds.			
9. Birthplace (City or town) (State or Country) <u>Newport, Ida</u> <u>Bonner Co Ida</u>					CONTRIBUTORY (Secondary) <u>Mother Kidney</u> (See 1 other side)			
10. Name of Father <u>Geo E Martin</u>					18. Where was disease contracted if not at the place of death? .....			
11. Birthplace of Father (City or town) (State or Country) <u>Kansas, USA</u>					(a) Did an operation precede death? ..... Date of .....			
12. Maiden name of Mother <u>Mable C Horner</u>					(b) Was there an autopsy? .....			
13. Birthplace of Mother (City or town) (State or Country) <u>Mont. USA</u>					(c) What test confirmed diagnosis? (Signed) <u>Dr. W. S. B. ...</u> M. D. <u>Oct 17</u> , 1921. Address <u>Newport, Wash</u>			
14. Informant <u>Mrs Geo E Martin (Mother)</u>					19. Place of Burial, Cremation or Removal <u>Newport</u> Date of Burial <u>Oct 14</u> , 1921			
Address <u>Newport, Wash</u>					20. Undertaker <u>Wm Davis Newport Wash</u> Address .....			
15. Filed <u>Dec 1</u> , 1921 <u>C. F. G. ...</u> Registrar.								

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions.  
(Insert numbers of unanswered questions)

(Signature of Undertaker)



MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

493-007-01K-433

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Canyon

City of Caldwell

No. \_\_\_\_\_ St.

Hospital Sanitarium

FULL NAME OF CHILD \_\_\_\_\_

RECEIVED

NOV 30 1921

BUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 3

File No. S 95609

Primary Registration District No. 1005

Registered No. 221

Sex of Child ..	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate? Yes	Date of Birth <u>10/ 7</u> (Month) (Day) (Year) <u>21</u>
-----------------	---	-----	--------------------------------	---------------------	--

FULL NAME <u>Roger Gordon Dille</u>	FATHER
RESIDENCE <u>Caldwell, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION <u>Insurance</u>	

FULL MAIDEN NAME <u>Elsie Fern McCormick</u>	MOTHER
RESIDENCE <u>Caldwell, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Washington</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth ...

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. M. Kaley

(Physician or midwife)

Given names added from a supplemental report.

19

Address Caldwell, Idaho

Filed Oct. 9- 1921

Registrar

Registrar

THIS FORM IS NOT TO BE USED FOR RECORDING BIRTHS

RECORD OF BIRTHS  
 This form is to be used for recording births only. It is not to be used for recording deaths or marriages. It is to be filled out by the attending physician or midwife at the time of the birth. It is to be filed in the birth record book of the hospital or clinic where the birth took place. It is to be kept for a period of ten years.

# CERTIFICATE OF BIRTH

BUREAU OF VITAL STATISTICS  
 STATE OF ILLINOIS

00000

File No.

Birth No.

Registered No.

Primary Registration District No.

FULL NAME OF CHILD

Sex of Child

Month of Birth

Day of Birth

Year of Birth

FATHER

MOTHER

Full Name

Full Name

Residence

Residence

Color

Color

Age at Last Birthday

Age at Last Birthday

Birthplace

Birthplace

Occupation

Occupation

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I, \_\_\_\_\_, a duly licensed physician or midwife, do hereby certify that I attended the birth of this child, who was \_\_\_\_\_ (Name of child) on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_ (Place of birth).

(Signature)

(Signature of physician or midwife)

When names added from a supplemental report.

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

655-112-814-713

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S 95676

County of Canyon

DEC 10 1921

City of Nampa

BUREAU OF VITAL

No. 915-14th Ave. St.

Registration District No.

File No.

Hospital

Primary Registration District No. 1006

Registered No.

FULL NAME OF CHILD

Infant Orenton

Sex of Child Male

Twins  
Triplet  
or other?  
(To be answered only in event of plural births)

and { Number  
in order  
of birth

Legitimate? Yes

Date of Birth Oct 12 21  
(Month) (Day) (Year)

FULL NAME

Duke Orenton

FATHER

RESIDENCE

Nampa

COLOR

White

AGE AT LAST BIRTHDAY

3-4  
(Years)

BIRTHPLACE

Missouri

OCCUPATION

Switchman

FULL MAIDEN NAME

Marie Lenna Patterson

MOTHER

RESIDENCE

Nampa

COLOR

White

AGE AT LAST BIRTHDAY

3-3  
(Years)

BIRTHPLACE

Missouri

OCCUPATION

Housewife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 3 A.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Geo. R. Proctor

Physician  
(Physician or midwife)

Given names added from a supplemental report.

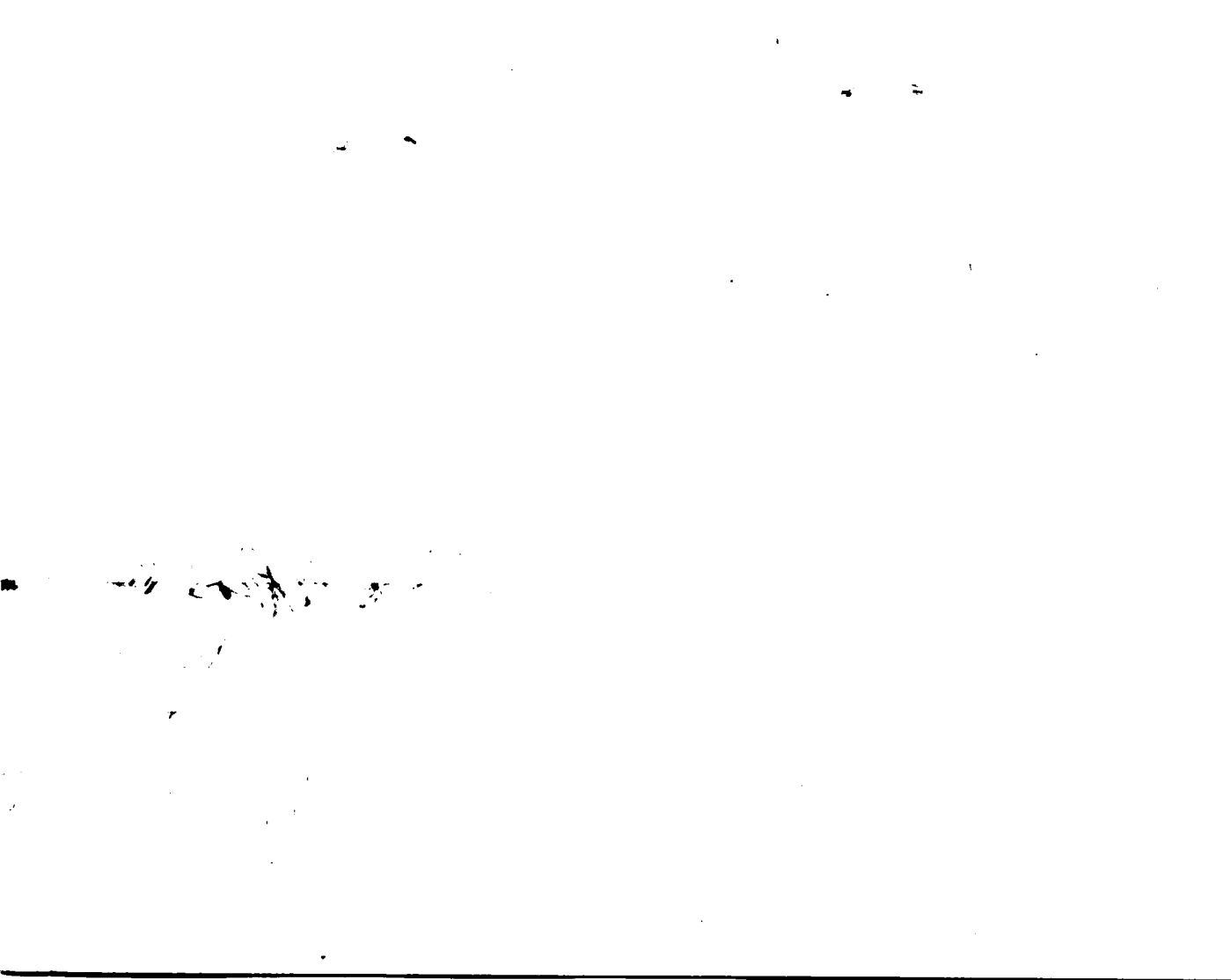
19

Address

Filed Dec 10 1921 Pearle Dodds

Registrar

Registrar



## 1. PLACE OF DEATH

County of Canyon  
City of Yampa

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## CERTIFICATE OF DEATH

RECEIVED

DEC 10 1921

BUREAU OF VITAL STATISTICS

Registration District No. 7Primary Registration District No. 1006

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 35920

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White

(Write the word.)

## 6. DATE OF BIRTH

Oct 12 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Duke Overtone

## 11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

## 12. MAIDEN NAME OF MOTHER

Carrie Lenna Patterson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. R. Proctor

(Address)

Yampa Ida

## 15.

Filed Dec 10 1921Pearl Dodde  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Oct 12 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still BornContributory  
(Secondary)

(Signed)

Geo. R. Proctor M. D.

\*State the illness causing death; or in deaths from violent causes, state (1) Means of injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

YampaDec 12 1921

## 20. UNDERTAKER

## ADDRESS

189-6

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

249-120-01X-966  
PLACE OF BIRTH

RECEIVED  
DEC 10 1921

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-22a-9-27

County of Canyon

BUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

City of Wilder

Registration District No.

File No.

No. St.

Primary Registration District No.

Registered No.

Caldwell Sanitarium  
Hospital

FULL NAME OF CHILD

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and (Number in order of birth)	Legiti- mate? Yes	Date of Birth 11/20 1921 (Month) (Day) (Year)
--------------	---	--------------------------------------	----------------------	--

FULL NAME Wayne W. Smith	FATHER
RESIDENCE Wilder, Idaho	
COLOR White	AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Neb.	
OCCUPATION Merchant	

FULL MAIDEN NAME Gene Rowland	MOTHER
RESIDENCE Wilder, Idaho	
COLOR White	AGE AT LAST BIRTHDAY 37 (Years)
BIRTHPLACE Iowa	
OCCUPATION Housewife	

Number of child of this mother, including present birth 1st Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn, at 4 P. M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

S. B. Dudley

M. D.  
(Physician or midwife)

Given names added from a supplemental report.

Address Caldwell, Idaho

Filed Nov. 24-1921

Registrar

Registrar

deposited upon the ground. **RECEIVED** at the office of the Clerk of the Court of the County of Los Angeles, California, this 1st day of June, 1906, the within and foregoing instrument, together with the fee thereon provided by law, and the same is hereby filed for record.

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY AND NAVAL RECORDS

SECRET

719-129014-415 Count  
PLACE OF BIRTH

County of Conyon

City of Trampa

No. R R No 4 St.

Hospital \_\_\_\_\_

RECEIVED  
NOV 30 1921  
BUREAU OF VITAL  
STATISTICS

Registration District No. 7

Primary Registration District No. 2006

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Form V. S. No. 11-25m-6-14-18

S95734

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Full Name of Child Still born 5<sup>th</sup> month

SEX OF CHILD <u>Boy</u>	Twin Triplet or other? (To be answered only in event of plural births)	X	and in order of birth	X	Legiti- mate?	<u>yes</u>	DATE OF BIRTH... <u>Aug. 29</u> 1921 (Month) (Day) (Year)
FULL NAME <u>Roy Parker</u>	FATHER				FULL MAIDEN NAME <u>Maggie P Davis</u>	MOTHER	
RESIDENCE <u>Trampa Ida</u>					RESIDENCE <u>Trampa Ida</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY... <u>39</u> (Years)					COLOR <u>white</u>	AGE AT LAST BIRTHDAY... <u>36</u> (Years)
BIRTHPLACE <u>Ida</u>					BIRTHPLACE <u>Kansas</u>		
OCCUPATION <u>Farmer</u>					OCCUPATION <u>Housewife</u>		

Number of child of this mother, including present birth... 9..... Number of children of this mother now living, including present birth... 8.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE  
I hereby certify that I attended the birth of this child, who was Still born (Born alive or stillborn), at 1041<sup>st</sup> A, M on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Murray  
M. D.  
(Physician or midwife)

Given names added from a supplemental report.

Address Trampa Ida  
Filed Oct 14 1921 Pearle Dodds  
Registrar

...to the ...

10/12/54

八五

RECEIVED

## CERTIFICATE OF DEATH

NOV 30 1921

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Canyon District No. 7  
City of Hamper Registration District No. 1006  
BUREAU OF VITAL STATISTICSFile No. 35946

Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Parker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White (Write the word.)

## 6. DATE OF BIRTH

(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

Roy Parker

## 11. BIRTHPLACE OF FATHER

(State or Country) Mo

## 12. MAIDEN NAME OF MOTHER

Maggie O. Davis

## 13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Menden  
Hamper IdahoFiled Oct 14 1921 Pearle Dodds

Local Registrar

## 16. DATE OF DEATH

Aug. 29 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Aug 29 1921 to 19  
that I last saw him alive on 19  
and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Menden M. D.  
8/20 1921 (Address) Hamper Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Hamper Idaho Aug 29 1921

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

189-2  
STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

318-10801K-689

PLACE OF BIRTH

STATE OF IDAHO

Form V. S. No. 11—20m-7-26-19

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED

NOV 30 1921

CERTIFICATE OF BIRTH

S 95737

County of CanyonCity of Nampa

BUREAU OF VITAL

STATISTICS

Registration District No. 7

File No.

No. \_\_\_\_\_ St.

Primary Registration District No. 2006

Registered No.

Hospital \_\_\_\_\_

FULL NAME OF CHILD

(Unnamed) Caywood

Sex of  
ChildTwin  
Triplet  
or other?  
(To be answered only in event of plural births)and { Number  
in order  
of birthLegiti-  
mate?

Yes

Date of  
Birth11-8-1921  
(Month) (Day) (Year)FULL  
NAME

Walter Nathaniel Caywood

FATHER

FULL  
MAIDEN  
NAME

Eagle June Whitson

MOTHER

RESIDENCE

418-16 Ave No - Nampa

RESIDENCE

Nampa Idaho

COLOR

White

AGE AT LAST  
BIRTHDAY22  
(Years)

COLOR

White

AGE AT LAST  
BIRTHDAY21  
(Years)

BIRTHPLACE

Colorado

BIRTHPLACE

Washington

OCCUPATION

Farmer

OCCUPATION

House Wife

Number of child of this mother, including present birth 3Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

(Still born)

(Born alive or stillborn)

3:15 A. M.

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

C. R. Meredith D.O.

(Physician or midwife)

Given names added from a supplemental report.

Address

Box 578 Nampa

Filed

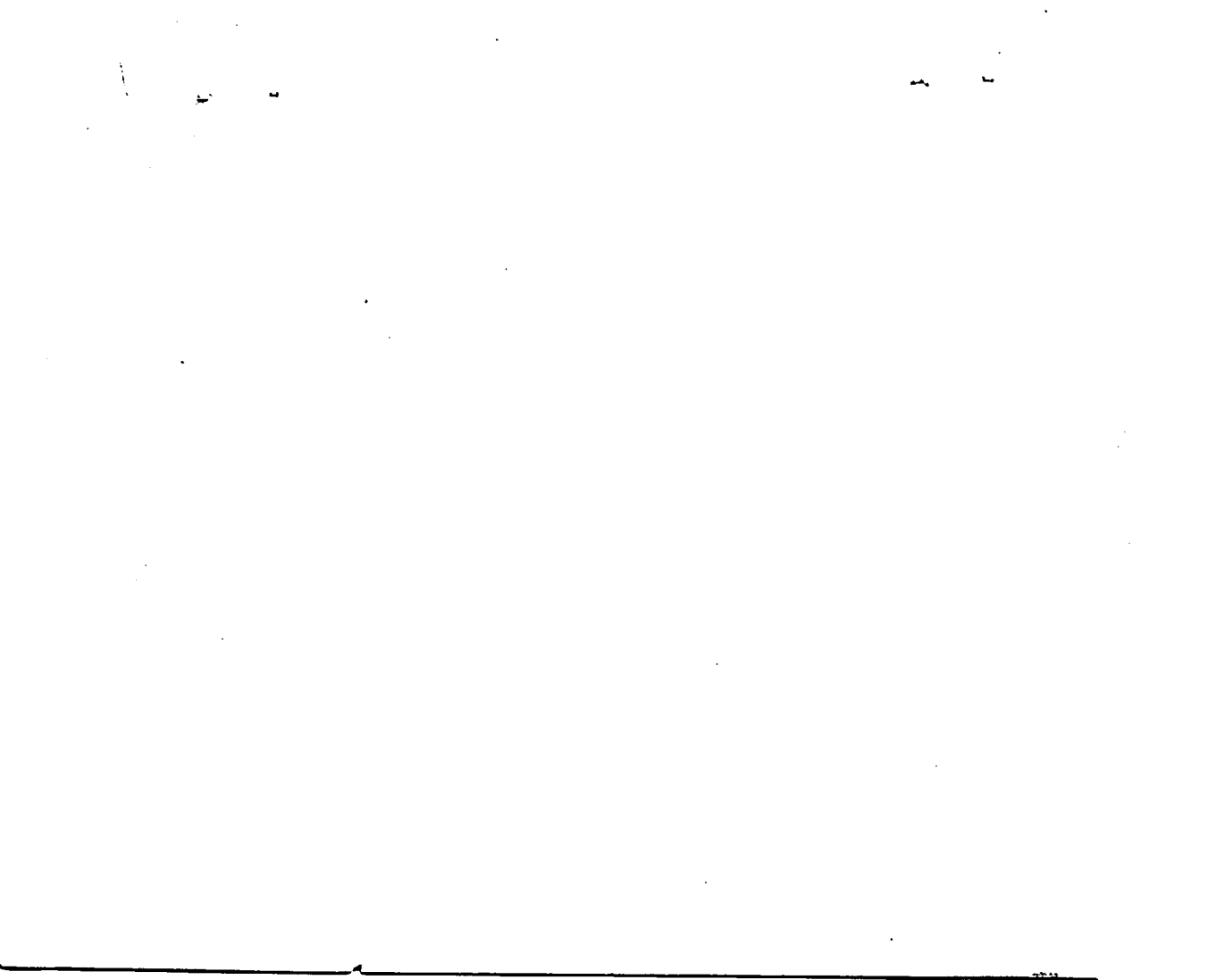
Nov. 10

1921

Pearl Jordan

Registrar.

Registrar.





MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED  
NOV 30 1921  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH. \_\_\_\_\_  
County of Canyon Registration District No. \_\_\_\_\_  
City of Nampa (No. \_\_\_\_\_) St. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Still Barn

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 35951

Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married  
(Write the word.)

6. DATE OF BIRTH 11-8-1921  
(Month) (Day) (Year)

7. AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
IF LESS than 1 day how many \_\_\_\_\_ hrs. or \_\_\_\_\_ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9. BIRTHPLACE

(State or Country) Canyon

10. NAME OF FATHER

Caywood W. N.

11. BIRTHPLACE OF FATHER

(State or Country) Colorado

12. MAIDEN NAME OF MOTHER

Hazel Jane Whitson

13. BIRTHPLACE OF MOTHER

(State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. R. Meredith

(Address) Nampa

15.

Filed 11/10

1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Stillborn 191\_\_\_\_  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at delivery 191\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 191\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Respiration  
mother's mother's absence  
of mother's care \_\_\_\_\_ ds.  
(Duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory \_\_\_\_\_  
(Secondary) \_\_\_\_\_  
(Signed) C. R. Meredith M. D.  
11/10 1921 (Address) Nampa

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL

Nampa

DATE OF BURIAL

11/8 1921

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

189-6  
**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

799-21016-555  
PLACE OF BIRTHSTATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Cassia RECEIVED DEC 1 1921  
 City of Burley BUREAU OF VITAL STATISTICS  
 No. \_\_\_\_\_ St. \_\_\_\_\_ District No. 117 File No. **S95765**  
 Hospital \_\_\_\_\_ Primary Registration District No. 2196 Registered No. 2129  
 FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>M</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Nov. 10</u> 192 <u>1</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					
What bactericidal solution was used in eyes? <u>Silver Nitrate</u>					
Number of child of this mother, including present birth <u>6</u>			Number of child of this mother now living, including present birth <u>5</u>		
FATHER FULL NAME <u>Earl Grinnell</u>			MOTHER FULL MAIDEN NAME <u>Gertie Hedham</u>		
RESIDENCE <u>Burley, Ida</u>			RESIDENCE <u>Burley, Ida</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>47</u> (Years)		COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>45</u> (Years)	
BIRTHPLACE <u>N. York</u>			BIRTHPLACE <u>New York</u>		
OCCUPATION <u>Farming</u>			OCCUPATION <u>Wife</u>		

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 6 a. M.  
 on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

Dr. J. C. Patterson  
 Physician  
 (Physician or midwife)

Give names added from a supplemental report.

Address \_\_\_\_\_

Filed \_\_\_\_\_

Burley, Ida  
Nov. 23 1921 Dr. J. C. Patterson  
 Registrar.

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD  
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

689-109-016-165  
PLACE OF BIRTH

RECEIVED  
DEC 10 1921  
BUREAU OF VITAL  
STATISTICS

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S95829

CERTIFICATE OF BIRTH

County of Cassia  
City of Oakley  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Hospital \_\_\_\_\_

Registration District No. 120 File No. AX 414  
Primary Registration District No. 2134 Registered No. 27

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>No</u> and { } Number in order of birth { }	Legitimate? <u>Yes</u>	Date of birth <u>Nov 2</u> 1921 (Month) (Day) (Year)
--------------------------	---	------------------------	---

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 2

FATHER  
FULL NAME George M. Jones  
RESIDENCE Oakley, Idaho  
COLOR White AGE AT LAST BIRTHDAY 65 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Mary Jones  
RESIDENCE Oakley, Idaho  
COLOR White AGE AT LAST BIRTHDAY 39 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Housewife

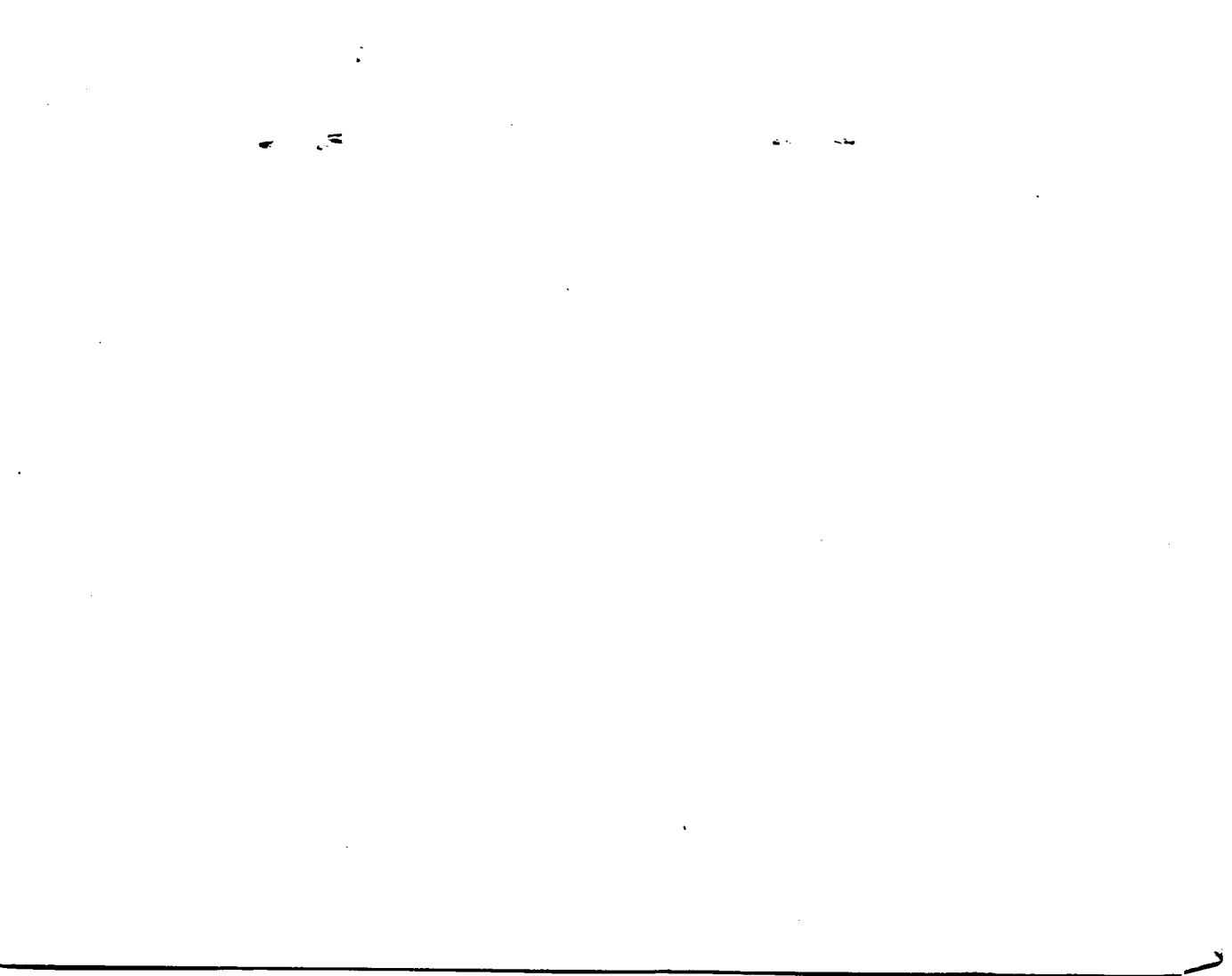
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn at 4:30 P. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) M. J. Jones  
(Physician or midwife)  
Address Oakley, Idaho  
Filed Dec 4 1921 M. J. Jones Registrar

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.



## CERTIFICATE OF DEATH.

35976 State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Blaine  
City of BlaineIf death occurs away from  
usual residence, give facts  
called for under special  
information.Registration District No. 139Primary Registration District No. 3197(No. DEC 1 1927)BUREAU OF VITAL  
STATISTICS

St.)

File No. XV 11Registered No. 2If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.2. FULL NAME no name (stillborn)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED. single  
(Write the word.)6. DATE OF BIRTH. Nov 7 1927  
(Month) (Day) (Year)7. AGE stillborn IF LESS than 1 day  
Yrs. Mos. ds. how many hrs. or  
min.?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work...  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which employ-  
ed (or employer).....

## 9. BIRTHPLACE

(State or Country) Idaho10. NAME OF  
FATHER11. BIRTHPLACE  
OF FATHER(State or Country) Utah12. MAIDEN NAME  
OF MOTHER13. BIRTHPLACE  
OF MOTHER(State or Country) Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Whitby(Address) Dakota Rd

## 15.

Filed Dec 4 1927Local Registrar W. O. Nelson

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Nov 7 1927  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

191....., to 191.....  
that I last saw h..... alive on 191.....  
and that death occurred on the date stated above, at ..... M.

## The CAUSE OF DEATH\* was as follows:

Stillborn  
(Duration) Yrs. mos. ds.Contributory  
(Secondary)(Duration) Yrs. mos. ds.  
(Signed) W. O. Nelson M. D.  
11/7 1927 (Address) Dakota Rd\*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1)  
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted  
if not at place of death?.....Former or  
usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Dakota Rd 11/8 1927

## 20. UNDERTAKER

## ADDRESS

James Whitby Dakota Rd

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

366212-1016-813  
PLACE OF BIRTH

RECEIVED

DEC 10 1921

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

95838

County of Carrie

City of Oakley

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 120

File No. XXV

Hospital \_\_\_\_\_

Primary Registration District No. 2199

Registered No. 7

FULL NAME OF CHILD

Not named (Stillborn)

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>/</u> and <u>/</u> Number in order of birth <u>/</u>	Legitimate? <u>Yes</u>	Date of birth. <u>Apr 12</u> 192 <u>1</u> (Month) (Day) (Year)
----------------------------	--	------------------------	---

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth... 3 ..... Number of child of this mother now living, including present birth... 2 .....

FULL NAME <u>Joseph Wesley Coape</u>	FATHER
RESIDENCE <u>Gurley Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Sawmill proprietor</u>	

FULL MAIDEN NAME <u>Beie Gladys Hall</u>	MOTHER
RESIDENCE <u>Burley Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>21</u> (Years)
BIRTHPLACE <u>Utah</u>	
OCCUPATION _____	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 6:50 P. M.  
on the date above stated. (born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Jose L. Rainey, M.D.

(Physician ~~midwife~~)

Give names added from a supplemental report.

Address

Oakley, Idaho

Filed

Dec 4 1921

W. H. Melton

Registrar.

Registrar.



389-201-021-573  
PLACE OF BIRTHCounty of... FranklinCity of... Preston, Ida.No. .... St

Hospital .....

FULL NAME OF CHILD .....

RECEIVED  
NOV 30 1921BUREAU OF VITAL  
STATISTICSRegistration District No. .... 2119Primary Registration District No. .... 27STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. &amp; No. 11-C-25m-4-23

S 95944  
File No. ....Registered No. .... 20.2

Sex of Child <u>Female.</u>	Twin Triplet or other? <u>    </u> (To be answered only in event of plural births)	and { Number in order of birth <u>    </u> }	Legitimate? <u>Yes.</u>	Date of Birth... <u>Oct. .... 1st. 1921</u> (Month) (Day) (Year)
-----------------------------	---	--	-------------------------	---

FULL NAME <u>Martin Christensen.</u>	FATHER
RESIDENCE <u>Mink Creek Ida.</u>	
COLOR <u>White.</u>	AGE AT LAST BIRTHDAY .... <u>31</u> (Years)
BIRTHPLACE <u>Mink Creek Ida.</u>	
OCCUPATION <u>Farmer.</u>	

FULL MAIDEN NAME <u>Lulu Egley.</u>	MOTHER
RESIDENCE <u>Mink Creek Ida.</u>	
COLOR <u>White.</u>	AGE AT LAST BIRTHDAY .... <u>32</u> (Years)
BIRTHPLACE <u>Mink Creek Ida.</u>	
OCCUPATION <u>Housewife.</u>	

Number of child of this mother, including present birth... 1 Number of children of this mother now living, including present birth... 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was... Stillborn. ... at... 7 ... A. .... M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) .... G. W. Tates
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address... Preston, Ida.Filed... Nov 2 1921 S. A. C. C. C.

Registrar

Registrar

CHAD PO STATE  
STATE OF IDAHO  
SOME OF THE PEOPLE WHO ARE

RECEIVED  
JAN 05 1922  
BURF

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho,..... JAN. 1 0. 1922 92...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Preston Idaho*  
of { Street .....  
Birth { County *Franklin*

Sex of Child..... *Female*

Father *Martin Christensen* Full Name

Mother *Lula Christensen* Full Maiden Name

File Number ..... 95944

Registration Dist. No. ....

Date of Birth ... *Oct 1st* ... 1921...

I HEREBY CERTIFY that the child described herein has been named:

*This child was still born and premature*  
Child's Name in Full

*Martin Christensen*  
Signature of Father or Mother



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

238-229-024-943  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED  
DEC 12 1921

CERTIFICATE OF BIRTH

S96005

County of Gooding

City of Gooding

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital Gooding

Registration District No. 24

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child

Female

Twins  
Triplet  
or other?

{ and }

Number  
in order  
of birth

(To be answered only in event of plural births)

Legitimate?

yes

Date of birth

Nov 29

1921

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 2

Number of child of this mother now living, including present birth 1

FULL NAME

Arthur B. Schultz

FATHER

FULL MAIDEN NAME

Avis M. Rutherford

MOTHER

RESIDENCE

Bliss Ida

RESIDENCE

Bliss Ida

COLOR

White

AGE AT LAST BIRTHDAY

3 5  
(Years)

COLOR

white

AGE AT LAST BIRTHDAY

31  
(Years)

BIRTHPLACE

Illwa's

BIRTHPLACE

Iowa

OCCUPATION

Farming

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at # P M. on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. H. Cromwell M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Gooding Ida

Filed

12-12 1921

J. H. Cromwell M.D.

Registrar.

Registrar.

DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.



JAN 10 1922

Dear Madam:

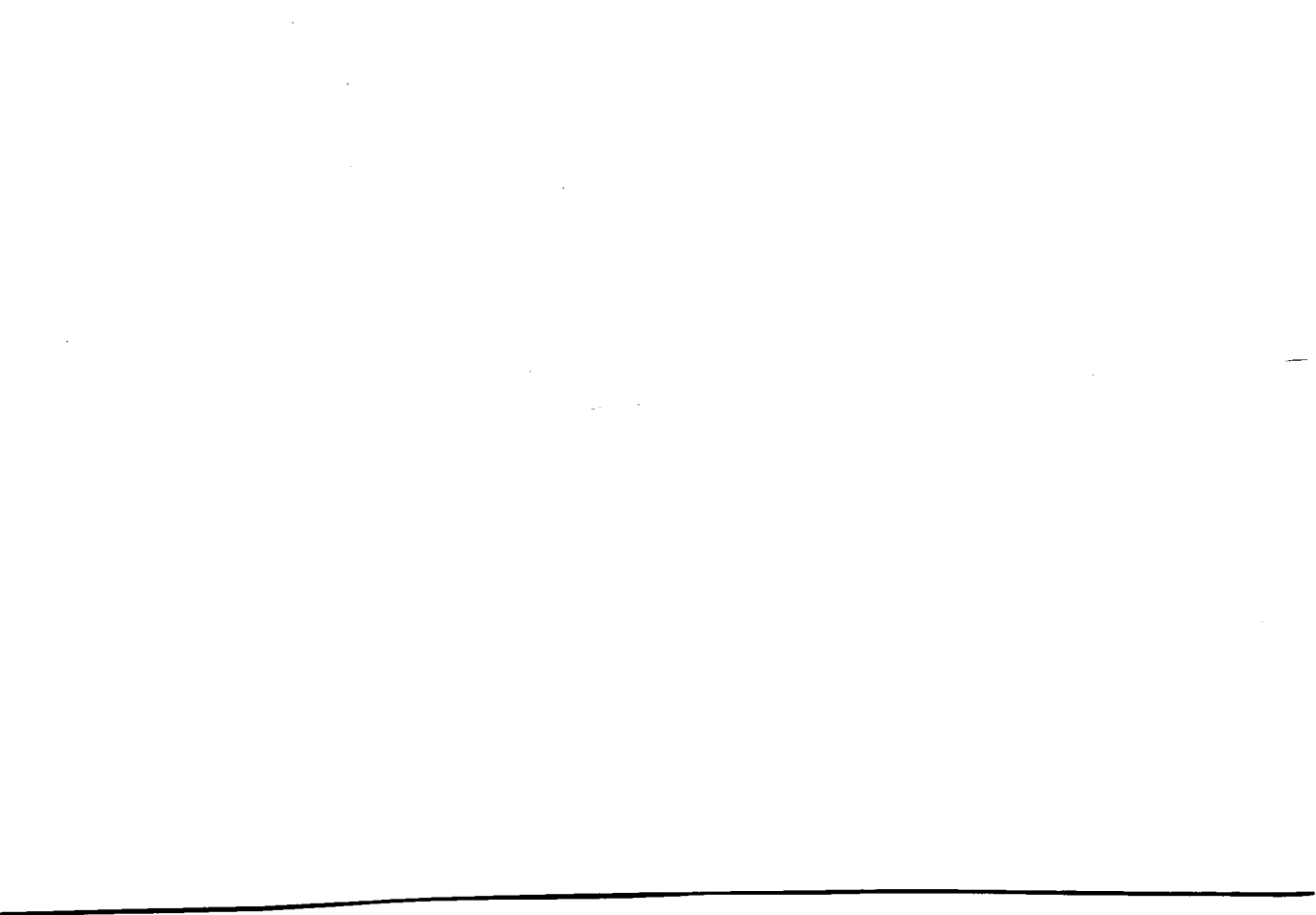
The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

## BUREAU OF VITAL STATISTICS.

Place of Birth { City *Cooding* .....  
Street *Cooding Loop* .....  
County *Cooding* .....  
File Number ..... 96005  
Registration Dist. No. ....  
Sex of Child..... Female .....  
Date of Birth *November 29* ..... 1921  
Father *Arthur B. Schultzy* ..... Mother *Iris Melrose Schultzy* .....  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Alice Dorachea Schultzy* .....  
Child's Name in Full  
*Iris Schultzy* .....  
Signature of Father or Mother



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH  
County of Gooding  
City of Gooding  
Registration District No. 24  
Primary Registration District No. \_\_\_\_\_  
(No. \_\_\_\_\_) (St. \_\_\_\_\_)

File No. 36046  
Registered No. \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Schultz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
*Write the word*

16. DATE OF DEATH Nov 29 19 21  
(Month) (Day) (Year)

6. DATE OF BIRTH Nov 29 19 21  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_ M. The CAUSE OF DEATH was as follows:

7. AGE 6 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

Stillborn  
Gestation less than 7 months  
(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

8. OCCUPATION (a) Trade, profession or particular kind of work. none (b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

Contributory (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (State or Country) Gooding Ida

(Signed) J. H. Cronwell M. D. 11/29 19 21 (Address) Gooding Ida

10. NAME OF FATHER Arthur B. Schultz

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Chris M. Rathford

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Arthur B. Schultz (Address) Bliss Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

15. Filed 12-1-21 19 21 J. F. Carey, M.D. Local Registrar

19. PLACE OF BURIAL OR REMOVAL Gooding Cemetery DATE OF BURIAL 12/1 19 21

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

7-681  
STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

A SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH  
384-205-1025-639  
County of Idaho

City of Grangeville

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Full Name of Child

RECEIVED  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH  
Registration District No. 103

Form V. S. No. 11--25m-6-16-18

File No. 96040

Registered No. 63

Primary Registration District No. 1001

not named Loring Lyda

SEX OF CHILD <u>F</u>	Twin Triplet or other? (To be answered only in event of plural births)	Number in order of birth	Legiti- mate? <u>yes</u>	DATE OF BIRTH <u>Nov 5 1921</u> (Month) (Day) (Year)
FULL NAME <u>Perry N Lyda</u>	FATHER		FULL MAIDEN NAME <u>Eva Oliver</u>	MOTHER
RESIDENCE <u>Grangeville</u>			RESIDENCE <u>Grangeville</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)		COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>29</u> (Years)
BIRTHPLACE <u>N. Carolina</u>			BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Laborer</u>			OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 5

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 1 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) G. B. Stockton  
(Physician or midwife)

on names added from a supplemental report.

Address Grangeville, Ida  
Filed see 1 1921 G. B. Stockton  
Registrar



The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City *Grangeville*  
Street .....  
County *Idaho*

File Number *96040*

Registration Dist. No. ....

Sex of Child ~~Male~~ *Female*

Date of Birth *November 5* 192*1*

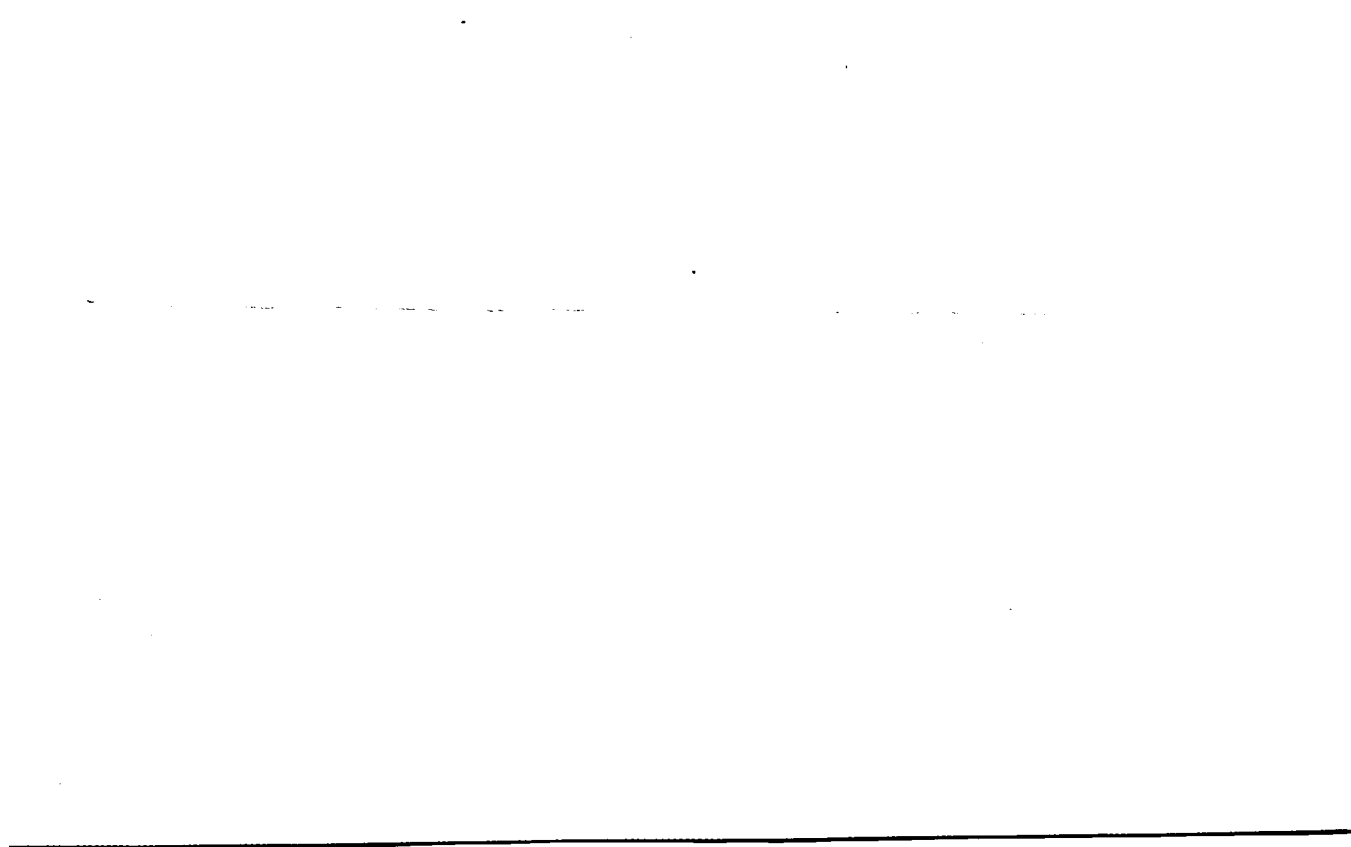
Father *Perry Nellie Lyda*  
Full Name

Mother *Eva Oliver*  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Loring Lyda*  
Child's Name in Full

*Mrs. Perry N. Lyda*  
Signature of Father or Mother





RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of IdahoCity of Grangerville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

DEC 8 1921

Registration District No. 103

BUREAU OF VITAL STATISTICS

Primary Registration District No. 1001

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 36051Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single  
(Write the word.)

6. DATE OF BIRTH

Nov 5

(Month)

(Day)

1921  
(Year)

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Grangerville

10. NAME OF FATHER

Perry N Lyda

11. BIRTHPLACE OF FATHER

(State or Country)

N. Carolina

12. MAIDEN NAME OF MOTHER

Eva Oliver

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. N. Lyda

(Address)

Grangerville Ida

15.

Filed

Dec 11921G. S. Stockton  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

13. DATE OF DEATH

Nov 5

(Month)

1921

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Premature birth,  
about 6 month fetus

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. S. Stockton M. D.11/5 1921 (Address) Grangerville

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Prairie View

DATE OF BURIAL

11/5 1921

20. UNDERTAKER

none

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

296-129.028-855  
PLACE OF BIRTH

County of Kootenai

City of Rathdrum

No. 1 St. 1

Hospital Forest Warren

FULL NAME OF CHILD William C. Brown

Sex of Child male  
Twin Triplet or other? no  
(To be answered only in event of plural births)

FATHER  
FULL NAME William C. Brown

RESIDENCE Rathdrum, Idaho

COLOR white AGE AT LAST BIRTHDAY 30  
(Years)

BIRTHPLACE Mich.

OCCUPATION farmer

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Registration District No. 30

File No. S 96115

Primary Registration District No. 1007

Registered No. 1155

Legitimacy yes

Date of Birth Nov. 29, 1921  
(Month) (Day) (Year)

MOTHER  
FULL MAIDEN NAME Mona D. Hanson

RESIDENCE Rathdrum, Idaho

COLOR white AGE AT LAST BIRTHDAY 23  
(Years)

BIRTHPLACE Mich.

OCCUPATION housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 8.00 A.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Frank Henry  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Rathdrum, Idaho  
Filed Dec 5 1921 D.D. Dierma  
Registrar

CHARTER STATE  
SECRETARY OF THE

SECRETARY OF THE

SECRETARY OF THE

**STATE OF IDAHO**  
**DEPARTMENT OF PUBLIC WELFARE**

RECEIVED

JAN 14 1922

Boise, Idaho,..... **JAN 7 9 1922**...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City ..... *Athol* .....  
                    { Street .....  
                    { County ..... *Spokane* .....

File Number ..... **96115** .....

Registration Dist. No. ....

Date of Birth ..... *November 29* 1921 .....

Sex of Child ..... *Male* .....

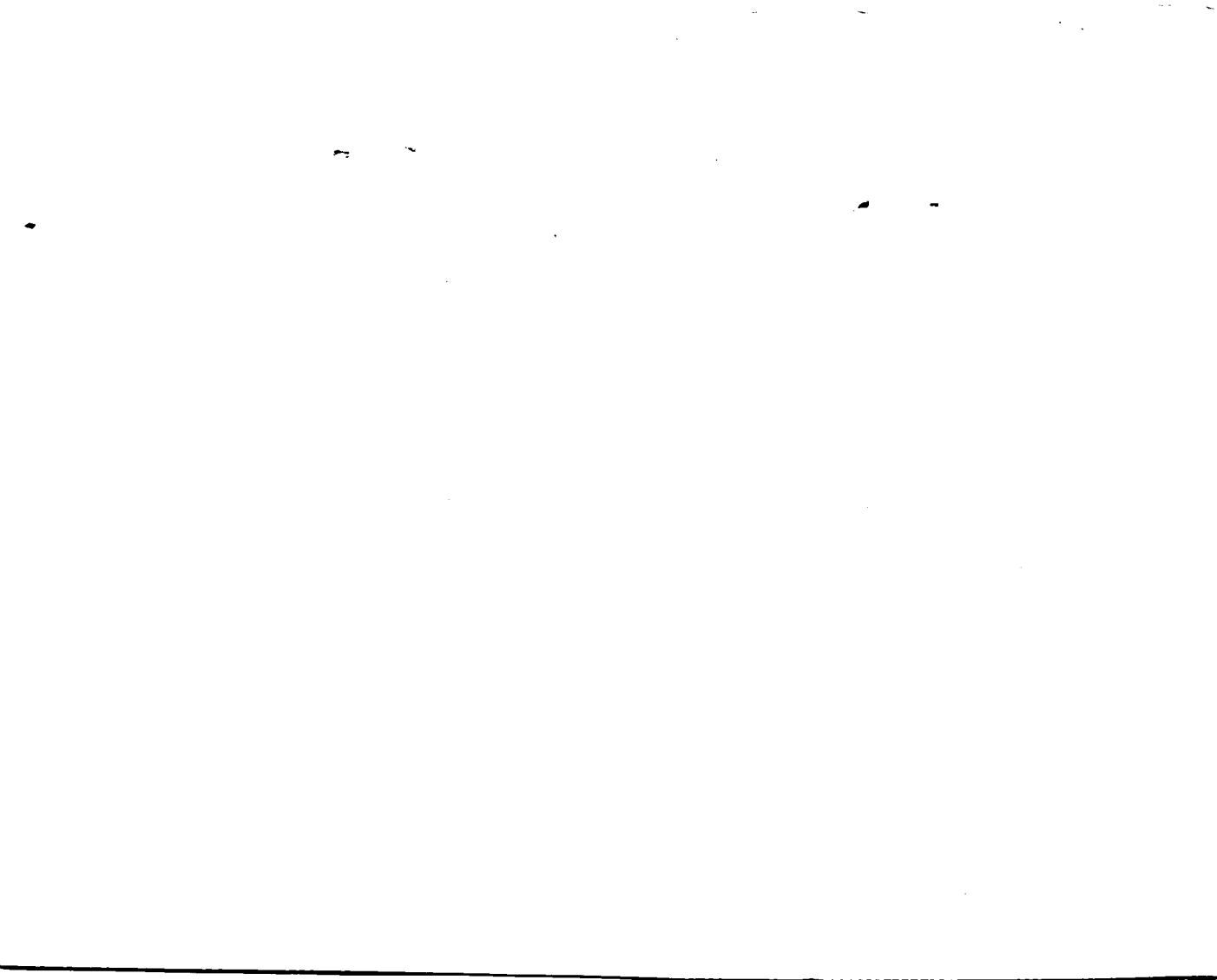
Father *William A. Brown*  
                    Full Name

Mother *Bora Parlee Henson*  
                    Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

..... *Forest Warren Brown* .....  
                    Child's Name in Full

..... *William A. Brown* .....  
                    Signature of Father or Mother



## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
DEC 1 1921  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

Registration District No.

Registration District No.

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dec 5 1921

D. H. Krema  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw h. alive on 19

and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH\* was as follows:

stillborn - dystocia -  
face presentation, persistent  
anterior-posterior position  
(Duration) Yrs. mos. ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

11/29/21 (Address) Ratholm, Ida.

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

189-  
A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

414-211028-687  
PLACE OF BIRTH

RECEIVED  
DEC 1 1921

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Kootenai  
City of Harrison

BUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. 126 File No. S96126  
Hospital \_\_\_\_\_ Primary Registration District No. 2284 Registered No. 9

FULL NAME OF CHILD Shellborn

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Nov 11</u> 192 <u>1</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	---

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth. 5 Number of children of this mother now living, including present birth. 4

FATHER  
FULL NAME James A. Madison  
RESIDENCE \_\_\_\_\_

MOTHER  
FULL MAIDEN NAME Alice Hygand  
RESIDENCE \_\_\_\_\_

COLOR White AGE AT LAST BIRTHDAY 27 (Years)

COLOR White AGE AT LAST BIRTHDAY 32 (Years)

BIRTHPLACE Wis

BIRTHPLACE Wis

OCCUPATION Shipping Clerk

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Shellborn at 11 M.  
on the date above stated. (Signature of or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. D. [Signature]  
(Physician or midwife)

Give names added from a supplemental report.

Address Harrison

192 \_\_\_\_\_

Filed 12-1 1921

Registrar.

Registrar.

# CERTIFICATE OF BIRTH

FULL NAME OF CHILD

Primary Registration District No.

Registration District No.

Sex of Child  
 Date of Birth  
 Place of Birth  
 Color

Weight  
 Length  
 Head Circumference

What hospital or institution was used in birth?

Name of mother, including maiden name

FATHER

MOTHER

NAME

MAIDEN NAME

RESIDENCE

RESIDENCE

COLOR

COLOR

AGE AT LAST BIRTHDAY

AGE AT LAST BIRTHDAY

DATE OF BIRTH

DATE OF BIRTH

STATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that the above is a true and correct statement of the birth of the child named above.

Signature of attending physician or midwife

When born, was the child registered in the birth records of the State of New York? If not, why not?

Signature of registrar

THIS CERTIFICATE OF BIRTH IS VALID FOR ALL PURPOSES IN THE STATE OF NEW YORK. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE APPROPRIATE OFFICIALS. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Boone Registration District No. 126 36077  
City of Harmon Primary Registration District No. 2208 St. 2  
BUREAU OF VITAL STATISTICS

File No. 2  
Registered No. 88

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Infant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Nov 11 1921  
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

12-1

1921

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 11 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Still born Infant

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

11-11-1921 (Address) Harmon, Ida

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harmon11-12-1921

20. UNDERTAKER

ADDRESS

None

151-2  
A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

695-207-228-714

PLACE OF BIRTH

RECEIVED

NOV 30 1921

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

DEPT. OF VITAL STATISTICS

County of Kootenai

BUREAU OF VITAL STATISTICS

City of Pathtown

Registration District No. 30

File No. S 96132

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 1051

Registered No. 1107

Hospital \_\_\_\_\_

FULL NAME OF CHILD (unnamed) Wiebe

Sex of Child <u>female</u>	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth <u>Sept 6 7 1921</u> (Month) (Day) (Year)
----------------------------	--	-----	--------------------------------	-----------------------------	---

FATHER  
FULL NAME Peter B. Wiebe

MOTHER  
FULL MAIDEN NAME Katharina Pauls

RESIDENCE Athol, Ida.

RESIDENCE Athol, Ida.

COLOR white AGE AT LAST BIRTHDAY 46  
(Years)

COLOR white AGE AT LAST BIRTHDAY 46  
(Years)

BIRTHPLACE Russia

BIRTHPLACE Russia

OCCUPATION farmer

OCCUPATION housewife

Number of child of this mother, including present birth 10 Number of children of this mother now living, including present birth 8

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 8.30 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) James H. Gray  
Physician  
(Physician or midwife)

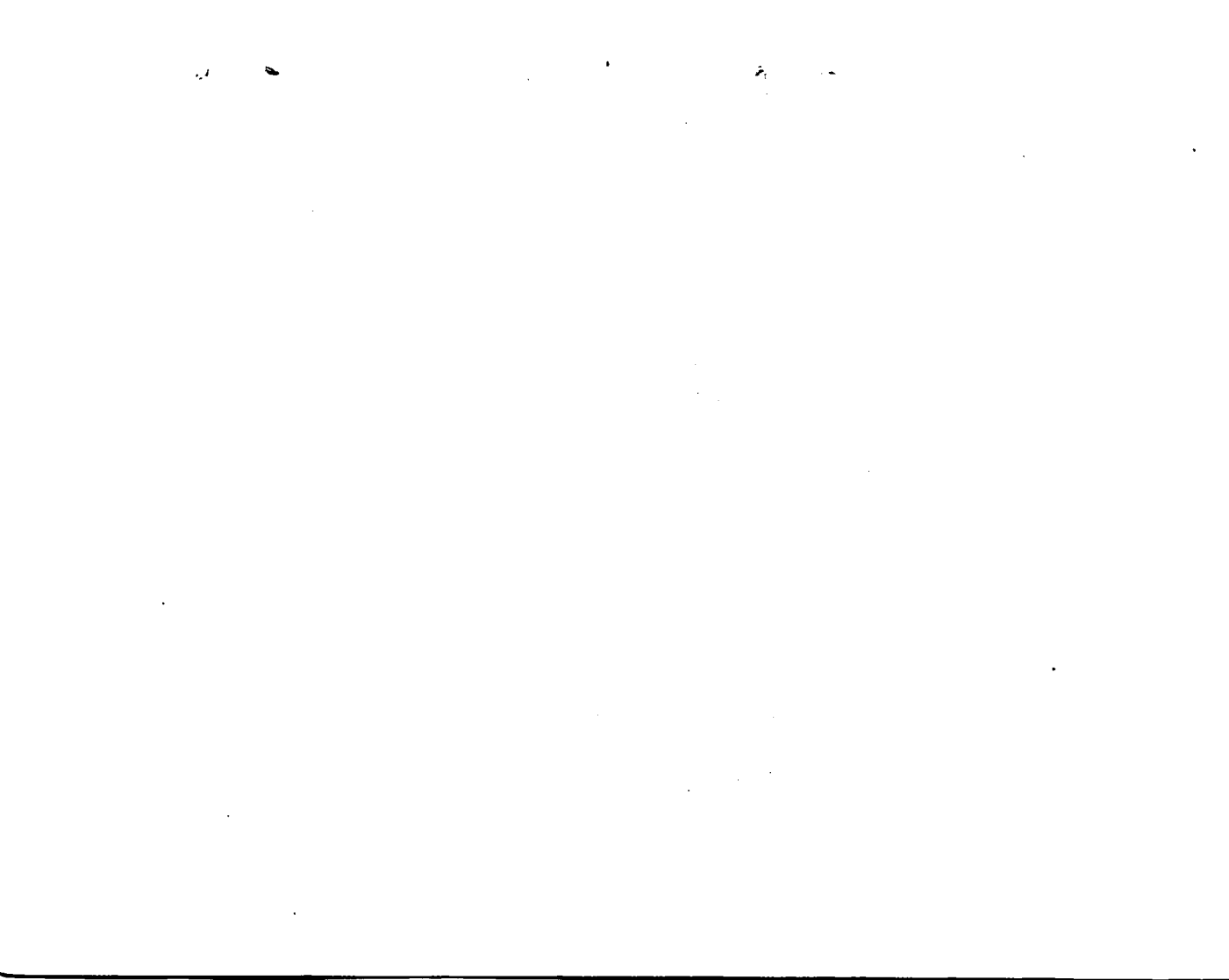
Given names added from a supplemental report.

Address Pathtown, Idaho

Filed Nov. 4 1921 L. D. Dremer

Registrar

Registrar



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Kootenai Registration District No. 30  
 City of Pathtun Primary Registration District No. 1057 St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

RECEIVED  
 NOV 30 1921  
 BUREAU OF VITAL STATISTICS

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics  
 File No. 36056  
 Registered No. 968

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single  
 (Write the word.)

## 6. DATE OF BIRTH

Sep 7 1921  
 (Month) (Day) (Year)

## 7. AGE

stillborn  
 Yrs. Mos. da.

IF LESS than 1 day  
 how many hrs.  
 or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer)

none

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

John B. Wiebe

## 11. BIRTHPLACE OF FATHER

(State or Country)

Russia

## 12. MAIDEN NAME OF MOTHER

Katarina Pauls

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John B. Wiebe

(Address)

Pathtun, Ida

## 15.

Filled

Nov. 4 1921

DD Drema

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Sep 7 1921  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from stillborn 1921 to 19

that I last saw h. alive on 19 M. and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH\* was as follows:

premature birth and  
atelectasis of lungs.

(Duration) Yrs. mos. ds.

Contributory  
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frank K. Kuy M. D.

1921

(Address) Pathtun, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Cathedral Idaho

Sep 8 1921

## 20. UNDERTAKER

## ADDRESS

O. W. G. Pathtun Idaho

151-22

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



IN RESERVED FOR BINDING

MAINLY WITH UNFADING INK THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

299-117-029-632

PLACE OF BIRTH

County of Latah

City of Genesee

No. .... St.

Hospital .....

FULL NAME OF CHILD .....

RECEIVED  
DEC 8 1917  
BUREAU OF VITAL STATISTICS

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Form V. S. No. 11-C-23m-3-3-17

S

Registration District No. 62

File No. 96231

Primary Registration District No. 2142

Registered No. 22

Allen Bird

Sex of Child <u>M</u>	Twin Triplet or other? <u>—</u> and { Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of Birth <u>Nov 17 1917</u> (Month) (Day) (Year)
-----------------------	---	------------------------	--

FATHER  
FULL NAME John Colberg  
RESIDENCE Genesee  
COLOR 27 AGE AT LAST BIRTHDAY 37  
(Years)  
BIRTHPLACE Idaho  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Ellen Olson  
RESIDENCE Genesee  
COLOR 12 AGE AT LAST BIRTHDAY 20  
(Years)  
BIRTHPLACE Iowa  
OCCUPATION Housewife

Number of child of this mother, including present birth. .... Number of children of this mother now living, including present birth. ....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Allen Bird at 94 M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. H. E. Kern

(Physician or midwife)

Given names added from a supplemental report.

..... 19.....

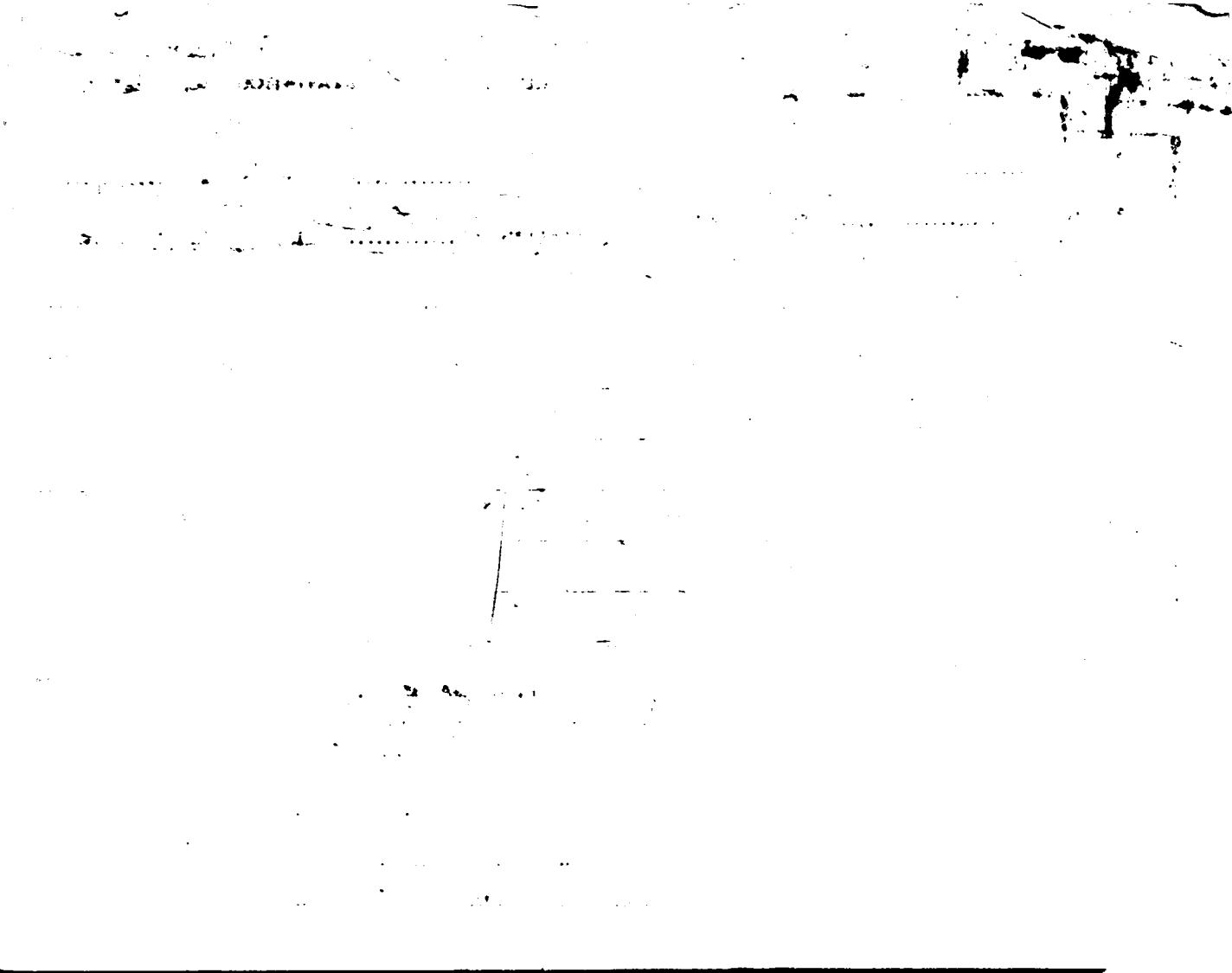
Address .....

.....

Filed 11-29-21 W. H. E. Kern

Registrar

Registrar



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Blaine*City of *Genese*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
DEC 8 1924BUREAU OF VITAL  
STATISTICS

2. FULL NAME

Registration District No. *64*Registration District No. *2142*

St.)

File No. *36104*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

*11-20-1924*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

*Still Born  
Strangulation in Utero*

(Duration)

Yrs.

mos.

ds.

Contributory  
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

*11-17-24*

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

34

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

296-114.033-663

## PLACE OF BIRTH

County of MadisonCity of Barton

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Registration District No. 100

File No. \_\_\_\_\_

Primary Registration District No. 2178Registered No. 326

Sex of Child

maleTwin  
Triplet  
or other?

and

Number  
in order  
of birthLegiti  
mate?yesDate of  
Birth11/14/21  
(Month) (Day) (Year)FULL  
NAMEFemy Kroh

FATHER

RESIDENCE

BartonFULL  
MAIDEN  
NAMEAlice Fok

MOTHER

RESIDENCE

Barton

COLOR

RussianAGE AT LAST  
BIRTHDAY47  
(Years)

COLOR

RussianAGE AT LAST  
BIRTHDAY31  
(Years)

BIRTHPLACE

Russia

BIRTHPLACE

Russia

OCCUPATION

Farmer

OCCUPATION

HousewifeNumber of child of this mother, including present birth 7Number of children of this mother now living, including present birth 6

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 5/30 A. M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Dr. O. Martin  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

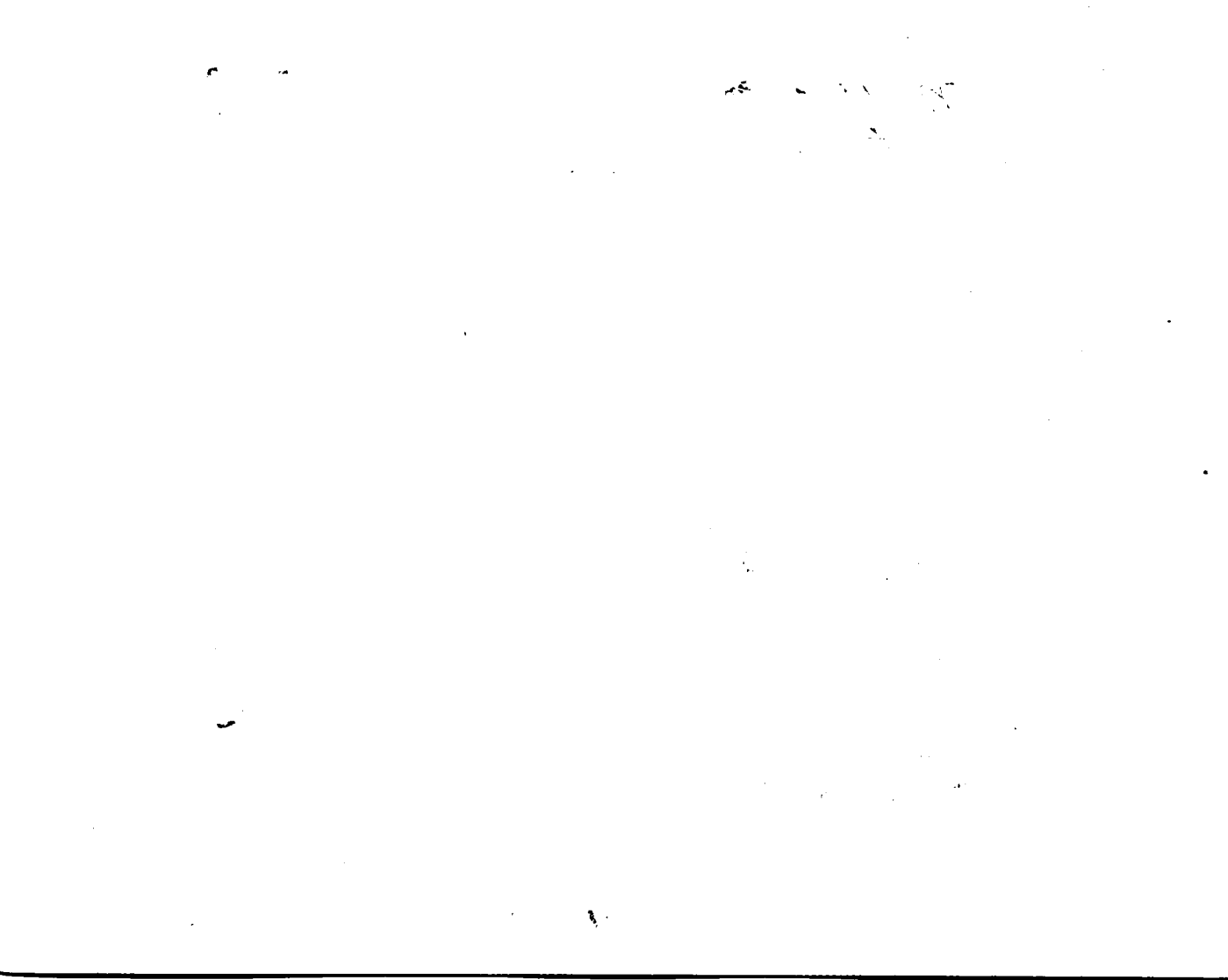
Reynolds, Idaho.

Filed

11/21 1921

Registrar

Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED

DEC 1 1921

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH. *Madison Co., Idaho*  
County of *Madison* District No. *100*  
City of *Burton* (No. *1* St.)  
BUREAU OF VITAL STATISTICS  
Registration District No. *2178*

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. *36121*  
Registered No. *86*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Not named infant*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Russian* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*  
(Write the word.)

6. DATE OF BIRTH.

*11 - 14 1921*  
(Month) (Day) (Year)

7. AGE

*✓* Yrs. *✓* Mos. *✓* ds.

IF LESS than 1 day  
how many *✓* hrs. or  
..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country)

*Madison Co., Idaho*

10. NAME OF FATHER

*Henry Kroh*

11. BIRTHPLACE OF FATHER

(State or Country)

*Russia*

12. MAIDEN NAME OF MOTHER

*Alice Hole*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Russia*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

*Henry Kroh*  
*Reidburg R.R. # Idaho*

15.

Filed

*11/14**1921*

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*11 - 14 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*11-14 1921* to *11-14 1921*  
that I last saw him *in* on *11-14 1921*  
and that death occurred on the date stated above, at *5:30* A.M.

The CAUSE OF DEATH\* was as follows:

*Stillborn*(Duration) *✓* Yrs. *✓* mos. *✓* ds.Contributory *Abnormal pelvis*  
(Secondary)(Duration) *✓* Yrs. *✓* mos. *✓* ds.(Signed) *W. Martin* M. D.*11-14 1921* (Address) *Reidburg Idaho*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Burton**11/14 1921*

20. UNDERTAKER

ADDRESS

*Father**Burton*

189-6  
A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

31/11



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

259-122-033-753  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Madison  
City of Independence  
No. \_\_\_\_\_ St. \_\_\_\_\_

CERTIFICATE OF BIRTH **S 96312**

Registration District No. 100 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2178 Registered No. 318

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____	and	Number in order of birth _____	Legiti- mate? <u>yes</u>	Date of birth <u>10-22-</u> 192 <u>1</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What bacteriocidal solution was used in eyes? none

Number of child of this mother, including present birth... 3 Number of child of this mother now living, including present birth... 2

FULL NAME Louise Serfert  
RESIDENCE Independence  
COLOR White AGE AT LAST BIRTHDAY 31 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Farmer

FULL MAIDEN NAME Julia Peterson  
RESIDENCE Independence  
COLOR White AGE AT LAST BIRTHDAY 25 (Years)  
BIRTHPLACE Utah  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Strickland at 2:45 P. M.  
on the date above stated. (mailed for test) (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A still-born child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Louise St. Serfert

(Physician or midwife) Mar

Give names added from a supplemental report.

Address Reynolds Idaho

Filed 11/21 1921

Registrar.

Registrar.



792-229.234-645

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of

NOV 30 1921

CERTIFICATE OF BIRTH

City of

BUREAU OF VITAL STATISTICS

Registration District No.

19

File No.

S 96324

No.

St.

Primary Registration District No.

2015

Registered No.

179

Hospital

FULL NAME OF CHILD

Stillborn

Sex of Child

Female

Twin  
Triplet  
or other?

{ and }

Number  
in order  
of birthLegiti  
mate?

Ja.

Date of  
Birth10  
(Month)29  
(Day)1921  
(Year)FULL  
NAME

Ben Libbon

RESIDENCE

Arequia

COLOR

White

AGE AT LAST  
BIRTHDAY58  
(Years)

BIRTHPLACE

Mass.

OCCUPATION

Purchaser

FULL  
MAIDEN  
NAME

Eliza Odell

RESIDENCE

Arequia

COLOR

White

AGE AT LAST  
BIRTHDAY43  
(Years)

BIRTHPLACE

Tex

OCCUPATION

Housewife

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.Stillborn, at 10 P. M.  
(Born alive or stillborn)\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed

Nov. 4 1921

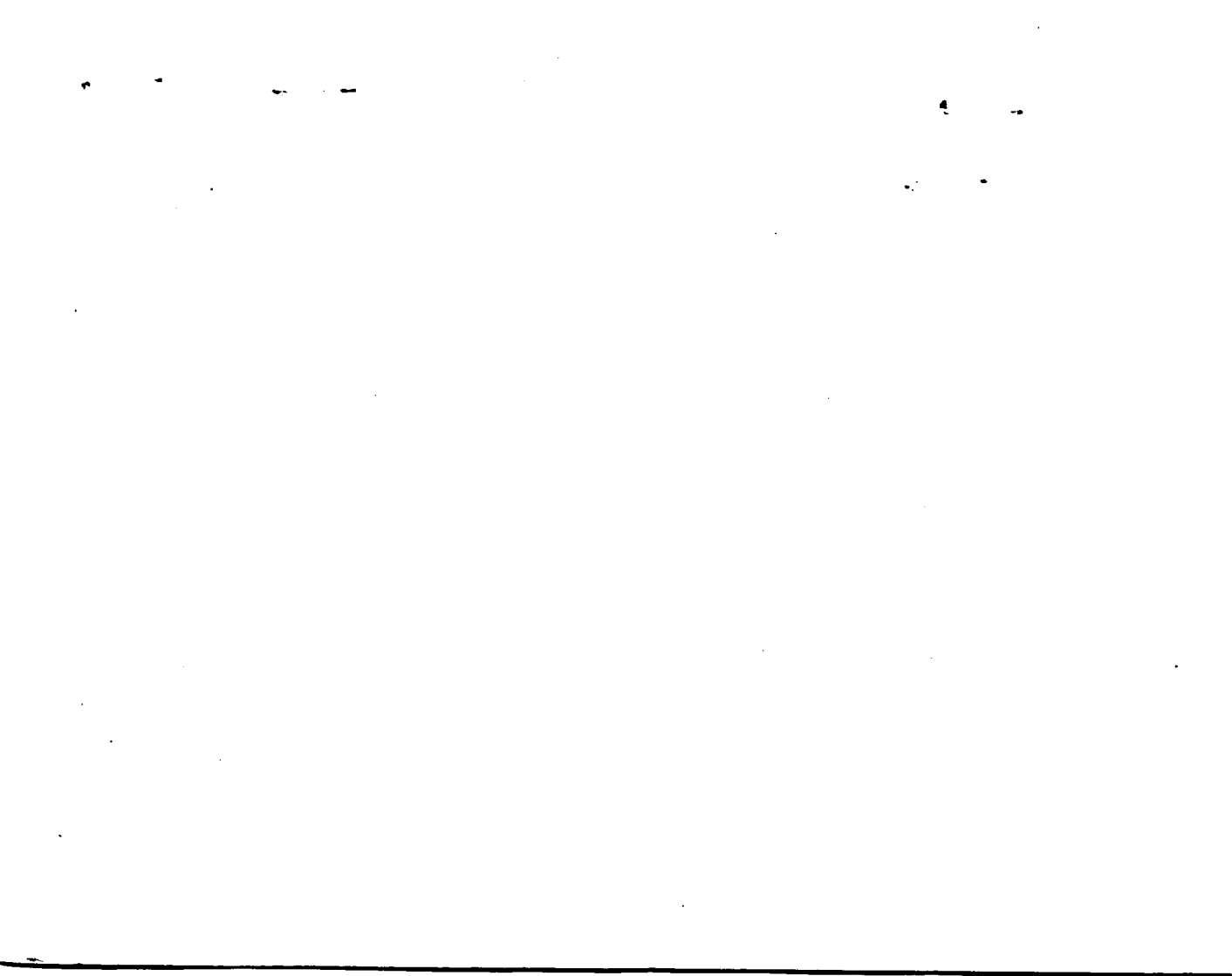
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH.

County of Mindoka District No. 19  
City of Acquia Registration District No. 2015  
St.)File No. 36132Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

RECEIVED  
NOV 30 1921  
BUREAU OF VITAL  
STATISTICSStillborn - Gibbons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

HWhite

(Write the word.)

## 6. DATE OF BIRTH.

Oct 29 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. 0 Mos. 0 ds.IF LESS than 1 day  
how many 0 hrs. or  
min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...none

## 9. BIRTHPLACE

(State or Country)

Acquia Ida.

## 10. NAME OF FATHER

Bert Gibbons

## 11. BIRTHPLACE OF FATHER

(State or Country)

Mass

## 12. MAIDEN NAME OF MOTHER

Eliza O'Dell

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

## (Informant)

Bert Gibbons

(Address)

Acquia

## 15.

Filed

Nov. 4 1921E. E. Elmore

Local Registrar

## 16. DATE OF DEATH

Oct 29 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

..... 191..... to ..... 191.....  
that I last saw h..... alive on ..... 191.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

StillbornContributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) E. E. Elmore M. D.19..... (Address) Acquia Ida.

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. .... mos. .... days In the State..... yrs. .... mos. .... days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Acquia Cemetery1921

## 20. UNDERTAKER

## ADDRESS

none

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

189-6  
**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

15-230-034-215

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Minidoka

City of Rupert

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

NOV 30 1921  
BUREAU OF VITAL  
STATISTICS  
Registration District No. 19

File No. 96346

Primary Registration District No. 2015 Registered No. 201

Stillborn

Sex of Child <u>M</u>	Twins or other? <u>Yes</u>	and	Number in order of birth <u>1</u>	Legitmate? <u>yes</u>	Date of Birth <u>Oct 30 1921</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

FATHER  
FULL NAME Karl M. Andreasen  
RESIDENCE Rupert  
COLOR white AGE AT LAST BIRTHDAY 32 (Years)  
BIRTHPLACE Denmark  
OCCUPATION Painter

MOTHER  
FULL MAIDEN NAME Gorgia M. Saviour  
RESIDENCE Rupert  
COLOR white AGE AT LAST BIRTHDAY 24 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Housewife

Number of child of this mother, including present birth 5 Number of children of this mother now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

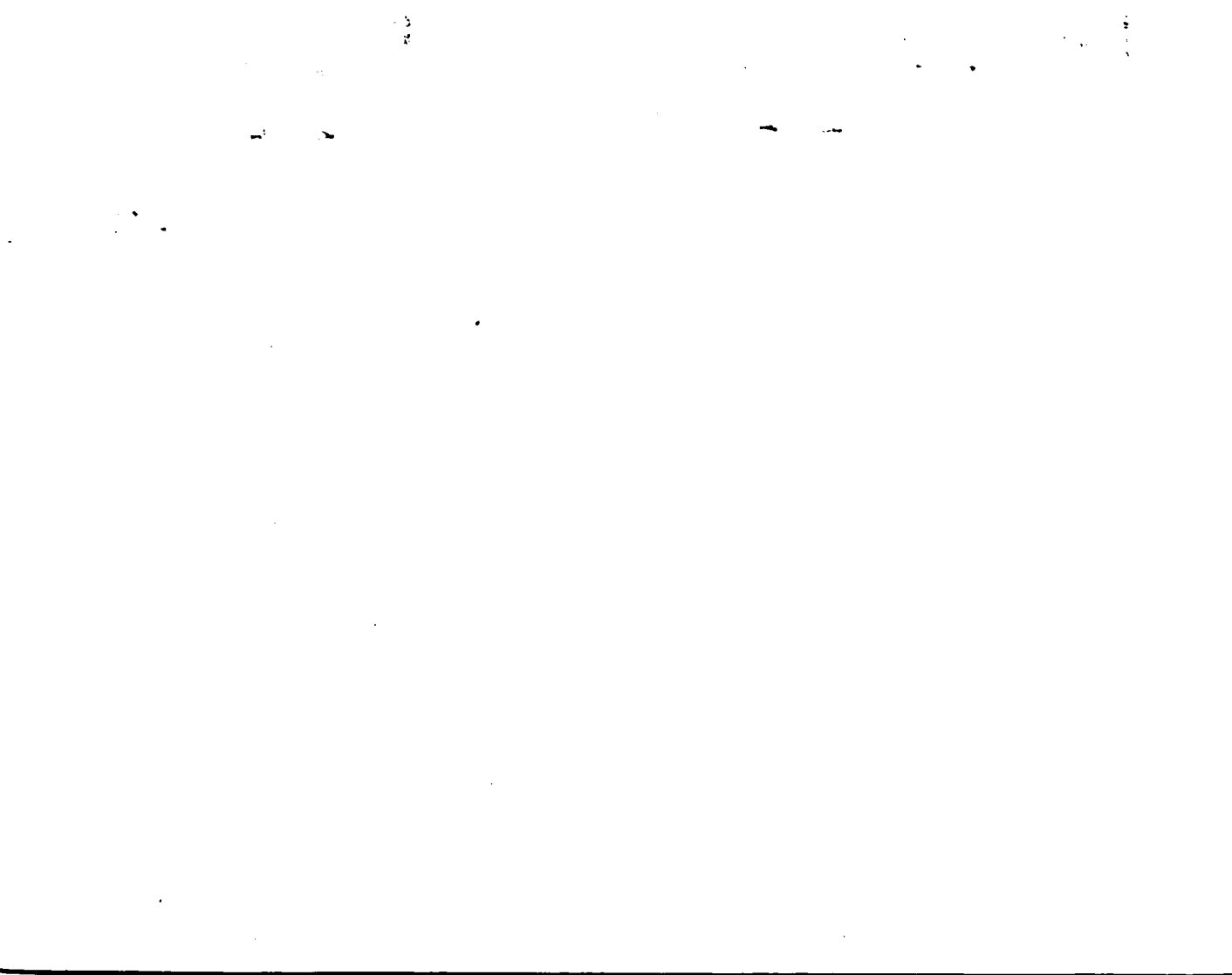
I hereby certify that I attended the birth of this child, who was stillborn, at 5 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. H. Ehlers  
(Physician or midwife)

Given names added from a supplemental report.

Address Rupert  
Filed Nov 6 1921 E. H. Ehlers  
Registrar





FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Minidoka Registration District No. 19  
 City of P Rupert Primary Registration District No. 2013  
 St.)

If death occurs away from  
 usual residence, give facts  
 called for under special  
 information.

2. FULL NAME

RECEIVED  
 NOV 30 1921  
 BUREAU OF VITAL  
 STATISTICS

Stillborn - Andressen

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 36130Registered No. 36

If death occurred in a hos-  
 pital, institution or camp,  
 give its NAME instead of  
 street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED.Fwhite

(Write the word.)

6. DATE OF BIRTH.

Oct. 30 1921  
 (Month) (Day) (Year)

7. AGE

2 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
 how many ..... hrs. or  
 ..... min.?

8. OCCUPATION

(a) Trade, profession or  
 particular kind of work...  
 (b) General nature of in-  
 dustry, business, or estab-  
 lishment in which employ-  
 ed (or employer).....

9. BIRTHPLACE

(State or Country)

P Rupert Ida.10. NAME OF  
FATHERKarl M. Andressen11. BIRTHPLACE  
OF FATHER

(State or Country)

Hennrich12. MAIDEN NAME  
OF MOTHERGeorgia M. Savio13. BIRTHPLACE  
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

mother  
P Rupert Ida

15.

Filed

Nov. 6 1921E. D. Elmer

Local Registrar

16. DATE OF DEATH

Oct. 30 1921  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
Oct. 30 1921, to Oct. 30 1921.

that I last saw her alive on ..... 191.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed) E. D. Elmer M. D.19..... (Address) P Rupert Ida.

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)  
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted  
 if not at place of death?.....

Former or  
 usual residence .....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

P Rupert Cemetery

191.....

20. UNDERTAKER

ADDRESS

none

189-681

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

345-215-034-962

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of MinidokaCity of Perfekt

No. \_\_\_\_\_ St. \_\_\_\_\_

RECEIVED  
DEC 12 1921  
BUREAU OF VITAL  
STATISTICS

## CERTIFICATE OF BIRTH

S  
96348  
File No. \_\_\_\_\_Primary Registration District No. 2015 Registered No. 203

Hospital \_\_\_\_\_

## FULL NAME OF CHILD

Stillborn

Sex of Child <u>Female</u>	<u>Twins</u> Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>yes</u>	Date of Birth <u>Nov. 15</u> 19 <u>21</u> (Month) (Day) (Year)
----------------------------	--	-----	--------------------------	------------------------	---

FULL NAME <u>James Lund</u>	FATHER
RESIDENCE <u>Perfekt</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)
BIRTHPLACE <u>Scotland</u>	
OCCUPATION <u>Shepherd</u>	

FULL MAIDEN NAME <u>Anne Robertson</u>	MOTHER
RESIDENCE <u>Perfekt</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Scotland</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

Stillborn at 12<sup>30</sup> P. M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

(Physician or midwife)

Given names added from a supplemental report.

19 \_\_\_\_\_

Address \_\_\_\_\_

Filed 12-6 1921

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

Dr

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

855-122-035-365  
PLACE OF BIRTH

RECEIVED

NOV 30 1921

BUREAU OF VITAL STATISTICS

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 96381

County of My Price

City of Lewiston

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 1009

Registered No. 808

FULL NAME OF CHILD \_\_\_\_\_

William Henrikson

(Certificate of no value without full name of child.)

Sex of Child \_\_\_\_\_

Male

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti-  
mate?

Yes

Date of  
birth

Oct. 22

1921

(Month)

(Day)

(Year)

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth \_\_\_\_\_

Number of child of this mother now living, including present birth \_\_\_\_\_

FULL  
NAME

FATHER

But Henrikson

RESIDENCE

Lewiston

COLOR

White

AGE AT LAST  
BIRTHDAY

48

(Years)

BIRTHPLACE

Denmark

OCCUPATION

Farmer

FULL  
MAIDEN  
NAME

MOTHER

Louisa Love

RESIDENCE

Lewiston

COLOR

White

AGE AT LAST  
BIRTHDAY

42

(Years)

BIRTHPLACE

OCCUPATION

At home

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_  
on the date above stated. \_\_\_\_\_ (stillborn)

\*When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature)

L. G. Perkins

(Physician or midwife)

Give names added from a supplemental report.

Address

Lewiston Idaho

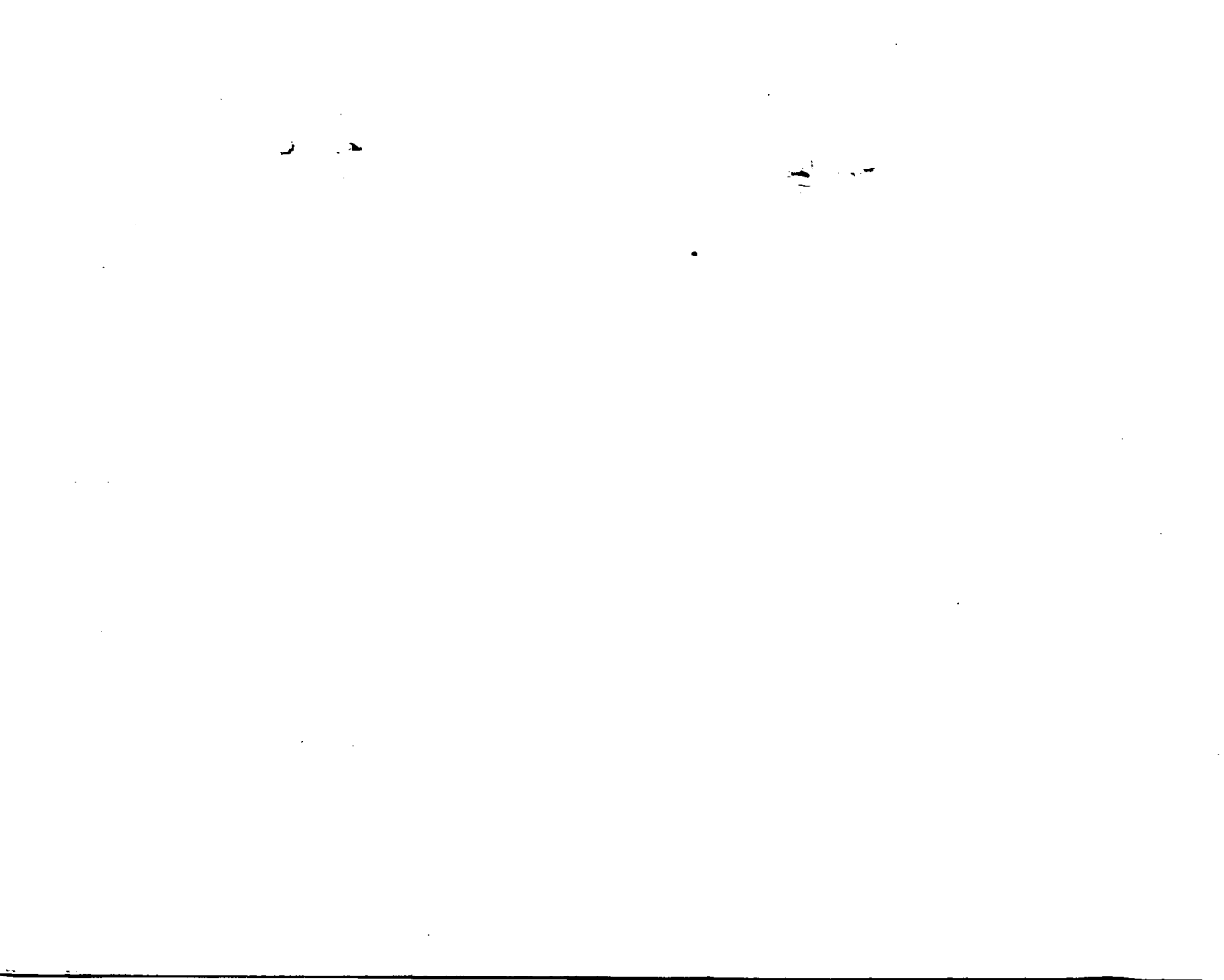
Filed

Nov 10 1921

Sam E. Burns

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of *Payson*City of *Lewiston*

If death occurs away from usual residence, give facts called for under special information.

RECEIVED  
NOV 30 1921  
BUREAU OF STATISTICSRegistration District No. *96*Registration District No. *1009*

St.)

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. *36169*Registered No. *20*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 2. FULL NAME

*Baby Henriksen*

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

*Male*

## 4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED*Single*  
(Write the word.)

## 6. DATE OF BIRTH

*Oct 22 1921*  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer)*Farmer*

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*Bert Henriksen*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Hennmark*

## 12. MAIDEN NAME OF MOTHER

*Louise Larr*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Mo.*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Bert Henriksen*

(Address)

*Lewiston Ida*

## 15.

Filed

*Nov 9 1921**Ernest E. Bruce*  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

*Oct 22 1921*  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19..... to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Still born.*

(Duration) Yrs. mos. ds.

Contributory *Large child and around neck*  
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *L. J. Erickson* M. D.*10/24/1921* (Address) *Lewiston Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Lewiston Oregon**Oct 22 1921*

## 20. UNDERTAKER

## ADDRESS

*Vassar Undertaking Co. Lewiston Idaho*

1898

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



251-1241035-251

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO

Form V. S. No. 11-C-25m-7-21-19

County of Nez Perce

NOV 30 1921

BUREAU OF VITAL STATISTICS

City of LewistonBUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

No. 0316-2nd St.Registration District No. 96

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 1009Registered No. 803

FULL NAME OF CHILD \_\_\_\_\_

Beach.

Sex of Child <u>male</u>	Twin Triplet or other? _____	and {	Number in order of birth _____	Legiti mate? <u>yes</u>	Date of Birth <u>Oct 24 - 1921</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

FULL NAME <u>Al. Beach</u>	FATHER
RESIDENCE <u>Lewiston, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Wash.</u>	
OCCUPATION <u>Laborer</u>	

FULL MAIDEN NAME <u>Agnes Beach</u>	MOTHER
RESIDENCE <u>Lewiston, Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>16</u> (Years)
BIRTHPLACE <u>Wash.</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth. 1 Number of children of this mother now living, including present birth. 1

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_, at \_\_\_\_\_, on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

John H. Olley

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Lewiston, Idaho

Filed

Nov 8 1921Susan E. Bruce

Registrar

Registrar

THIS IS A PRELIMINARY RECORD  
 MADE BY THE REGISTRAR FOR BIRTHING  
 AND IS NOT TO BE USED FOR ANY OTHER PURPOSE  
 IN CASE OF DOUBT OR DISCREPANCY THE REGISTRAR SHALL BE THE FINAL AUTHORITY

STATE OF IDAHO  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF BIRTH

RECEIVED

PLACE OF BIRTH

County of

City of

No.

Hospital

FULL NAME OF CHILD

Sex of Child

Twins  
 Triplets  
 or others?  
 (To be answered only in event of plural births)

Number  
 in order  
 of birth

Legitimate  
 or illegitimate?

Date of Birth

(Year) (Month) (Day)

MOTHER

FULL  
 MAIDEN  
 NAME

FATHER

FULL  
 NAME

RESIDENCE

RESIDENCE

AGE AT LAST  
 BIRTHDAY

(Years)

COLOR

AGE AT LAST  
 BIRTHDAY

(Years)

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

Number of child of this mother, including present birth. Number of children of this mother now living, including present birth.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was

(Signature of Physician or Midwife)

When there was no attending physician or midwife, the father, householder, etc., should make this return. A stillborn child is one that is born dead and not after the birth of the mother.

Given names added from a supplemental report.

Address

Registrar

Registrar

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Nez Perce District No. 96  
City of Lewiston Registration District No. 1009  
St. Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RECEIVED  
NOV 30 1921  
BUREAU OF VITAL  
STATISTICS

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 36172Registered No. 723

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Infant  
(Write the word.)

6. DATE OF BIRTH.

Oct 24 1921  
(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day  
how many hrs. or  
0 min.

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Cil. Beach

11. BIRTHPLACE OF FATHER

(State or Country) Wash

12. MAIDEN NAME OF MOTHER

Agnes Beach

13. BIRTHPLACE OF MOTHER

(State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cil. Beach(Address) Lewiston Ida

15.

Filed

Nov 10 1921 Simon E. Price  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 24 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Stillborn  
5 months uterine gestation  
(Duration) Yrs. mos. ds.

Contributory  
(Secondary)(Signed) Paul J. Johnson M. D.19. (Address) Lewiston Idaho

\*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida 10/25 1921

20. UNDERTAKER

ADDRESS

None (Within Lewiston)

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

1896  
STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

689-226035-431

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11—25m-1-1-13

County of Nez Perce RECEIVED  
DEC 10 1921

City of \_\_\_\_\_ BUREAU OF VITAL  
STATISTICS

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2174

File No. S 96403

Registered No. 27

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child <u>Female</u>	Twin Triglet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of Birth <u>Nov 26</u> 19 <u>21</u> (Month) (Day) (Year)
FATHER FULL NAME <u>Charles N. White</u> RESIDENCE <u>1/2 mile north of Lapwai</u> COLOR <u>Nez Perce Indian</u> AGE AT LAST BIRTHDAY <u>28</u> (Years) BIRTHPLACE <u>Lapwai Ida</u> OCCUPATION <u>None</u>			MOTHER FULL MAIDEN NAME <u>Delia Mcatty</u> RESIDENCE <u>1/2 mile north of Lapwai</u> COLOR <u>Indian</u> AGE AT LAST BIRTHDAY <u>27</u> (Years) BIRTHPLACE <u>Julietta Ida</u> OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 50 M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) L. D. Smith M.D.  
(Physician or midwife)

Given names added from a supplemental report.

Address Fort Lapwai Ida  
Filed Dec 9th 1921  
J. R. Rigg  
Registrar



of

1944

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 01-11-2001 BY 60322 UCBAW/STP

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

964-107.003-415

PLACE OF BIRTH

County of Bannock

City of McCammon

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital Swain

FULL NAME OF CHILD Lester Remriell

RECEIVED  
NOV 30 1921

BUREAU OF VITAL  
STATISTICS

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C--25m-7-21-19

S 96502

Registration District No. 75

File No. 75

Primary Registration District No. 2161

Registered No. 4030

Sex of Child <u>boy</u>	Twins or other? <u>Triplet</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of Birth <u>Oct 7 1921</u> (Month) (Day) (Year)
-------------------------	--------------------------------	-----	-----------------------------------	------------------------	---

FATHER  
FULL NAME Lester Remriell  
RESIDENCE McCammon, Ida.  
COLOR white  
AGE AT LAST BIRTHDAY 28  
(Years)  
BIRTHPLACE Idaho  
OCCUPATION farmer

MOTHER  
FULL MAIDEN NAME Bulah Davis  
RESIDENCE McCammon, Ida.  
COLOR white  
AGE AT LAST BIRTHDAY 23  
(Years)  
BIRTHPLACE Idaho  
OCCUPATION farmer Huf.

Number of child of this mother, including present birth. 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born, at 1:30 P. M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Wilson J. McDill

Phys. & Surg.  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

McCammon Ida

Filed

11/1 1921

Registrar

Registrar

80-208



OFFICE OF THE ATTORNEY GENERAL

FILE NO.

RECEIVED

1964

RECEIVED  
FEB 11 1964  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

[Faint, mostly illegible text in the main body of the document, appearing to be a letter or report.]

[Faint, mostly illegible text at the bottom of the document, possibly a signature block or footer.]

2



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

168-203.042-845  
PLACE OF BIRTH

RECEIVED

DEC 10 1921

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Twin Falls,

City of Twin Falls

BUREAU OF VITAL  
STATISTICS

CERTIFICATE OF BIRTH

96643

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 36

File No. \_\_\_\_\_

Hospital home

Primary Registration District No. \_\_\_\_\_

Registered No. 83

FULL NAME OF CHILD \_\_\_\_\_

no name

(Certificate of no value without full name of child.)

Sex of  
Child female

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

} and {

Number  
in order  
of birth

Legiti-  
mate? yes

Date of  
birth Nov. 3 1921  
(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth... 6

Number of child of this mother now living, including present birth... 5

FULL  
NAME

FATHER

George H. Johnson

RESIDENCE

Twin Falls, Ida. R.F.D.

COLOR

W

AGE AT LAST  
BIRTHDAY 32  
(Years)

BIRTHPLACE

Utah

OCCUPATION

farmer

FULL  
MAIDEN  
NAME

MOTHER

Martha Hunsaker

RESIDENCE

Twin Falls, Ida. R.F.D.

COLOR

W

AGE AT LAST  
BIRTHDAY 28  
(Years)

BIRTHPLACE

Mtah

OCCUPATION

Hw.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 4 P. M.  
on the date above stated. (Born alive or stillborn)

\* When there was no attending physician or  
midwife, then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature) \_\_\_\_\_

J. N. Davis

physician

(Physician or midwife)

Give names added from a supplemental report.

Address Kimberly, Idaho

Filed Nov. 13, 1921

J. N. Davis

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

112-231042-395  
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Twin Falls  
City of Triler, Ida  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Registration District No. 25 File No. S96687

Hospital \_\_\_\_\_ Primary Registration District No. 25th Registered No. \_\_\_\_\_

FULL NAME OF CHILD Evelyn Casper

(Certificate of no value without full name of child.)

Sex of Child <u>Girl</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and } Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Sept. 21</u> 192 <u>1</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	--

What bactericidal solution was used in eyes? \_\_\_\_\_

Number of child of this mother, including present birth \_\_\_\_\_ Number of child of this mother now living, including present birth \_\_\_\_\_

FATHER  
FULL NAME Henry L. Casper  
RESIDENCE Triler, Ida  
COLOR White AGE AT LAST BIRTHDAY 27 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Rancher

MOTHER  
FULL MAIDEN NAME Clara Lieberman  
RESIDENCE Triler, Ida  
COLOR White AGE AT LAST BIRTHDAY 20 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 6:30 P. M.  
on the date above stated. (Signature of stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
\_\_\_\_\_  
Registrar.

(Signature)

Address \_\_\_\_\_

Filed Sept 22 1921

Dr. A. Newberry  
(Physician or midwife)  
Triler, Ida  
Sept 22 1921  
Registrar.

STATEMENT OF BIRTH

Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

Copyright © 1997 by John Wiley & Sons, Inc.

[illegible]

10-10-68

NAME	FATHER	MOTHER

DATE OF BIRTH	COLOR	DATE OF BIRTH	COLOR
DATE OF BIRTH	COLOR	DATE OF BIRTH	COLOR

NOTES 40330

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

[illegible]

(S) [REDACTED] (S)

SECRET

SECRET

100-443887-100

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH

County of *Jefferson*

City of *Clair*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. *25*

Primary Registration District No. *2056*

BUREAU OF VITAL STATISTICS

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. *36218*  
Registered No. ....  
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Female*

4. COLOR OR RACE

*white*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

*Sept 21 1921*  
(Month) (Day) (Year)

7. AGE

*21*

IF LESS than 1 day  
how many .... hrs. or  
..... Yrs. .... Mos. .... ds. .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*H. G. Jasper*

11. BIRTHPLACE OF FATHER

(State or Country)

*Nebraska*

12. MAIDEN NAME OF MOTHER

*Clara Kurnamm*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Minnesota*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*H. G. Jasper*

(Address)

*Idaho*

15.

Filed *Sept. 22 1921*

*A. T. Humberg*  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Sept 21 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw h... alive on 191...

and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH\* was as follows:

*Still Born.*

(Duration) Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) Yrs. .... mos. .... ds.

(Signed) *D. T. A. Humberg* M. D.

19... (Address) *Idaho*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death .... yrs. .... mos. .... days, State .... yrs. .... mos. .... days

Where was disease contracted

If not at place of death?

Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

*Clair Cemetery*

DATE OF BURIAL

*Sept 23 1921*

20. UNDERTAKER

*J. E. Drake*

ADDRESS

*Idaho*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

7-631  
**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia*, *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoncum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Mucosae*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

266-125-042-666  
PLACE OF BIRTH

County of Blaine Falls

City of Murtaugh

No. \_\_\_\_\_ St.

Hospital \_\_\_\_\_

FULL NAME OF CHILD

RECEIVED  
DEC 10 1921  
BUREAU OF VITAL  
Registration District No. 36

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

S 96692

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_ Registered No. 94

not named

Sex of Child <u>Male</u>	Twin Triplet or other? <u>1</u> and <u>1</u> (To be answered only in event of plural births)	Number in order of birth <u>1</u>	Legiti mate? <u>Yes</u>	Date of Birth <u>Nov 25 1921</u> (Month) (Day) (Year)
--------------------------	---	--	----------------------------	--

FULL NAME <u>M. B. Bailey</u>	FATHER
RESIDENCE <u>Murtaugh</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>40</u> (Years)
BIRTHPLACE <u>Id.</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Arilla J. Woodhouse</u>	MOTHER
RESIDENCE <u>Murtaugh</u>	
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>38</u> (Years)
BIRTHPLACE <u>Id.</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 7

### CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still-born, at 11 P. M.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) B. A. Price  
Murtaugh  
(Physician or midwife)

Given names added from a supplemental report.

Address Murtaugh

Filed Nov 30 19 21 J. M. Davis

Registrar

Registrar





1136

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

449.203644-336  
PLACE OF BIRTH

County of Washington

City of Weiser

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Registration District No. 86

File No. 96717

Primary Registration District No. 1010

Registered No. 23

FULL NAME OF CHILD Geraldine May Durkee

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>#</u>	and {	Number in order of birth <u>3</u>	Legitimate? <u>Yes</u>	Date of birth <u>3</u> <u>1921</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FATHER		MOTHER	
FULL NAME	<u>Edward C. Durkee</u>	FULL NAME	<u>Mary Virginia Lloyd</u>
RESIDENCE	<u>Weiser, Idaho</u>	RESIDENCE	<u>Weiser, Idaho</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>42</u> (Years)	AGE AT LAST BIRTHDAY	<u>42</u> (Years)
BIRTHPLACE	<u>Kansas</u>	BIRTHPLACE	<u>Nebraska</u>
OCCUPATION	<u>Clerk</u>	OCCUPATION	<u>House-wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Still Born at 5 p M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. B. Shirley, M.D.

(Physician or midwife)

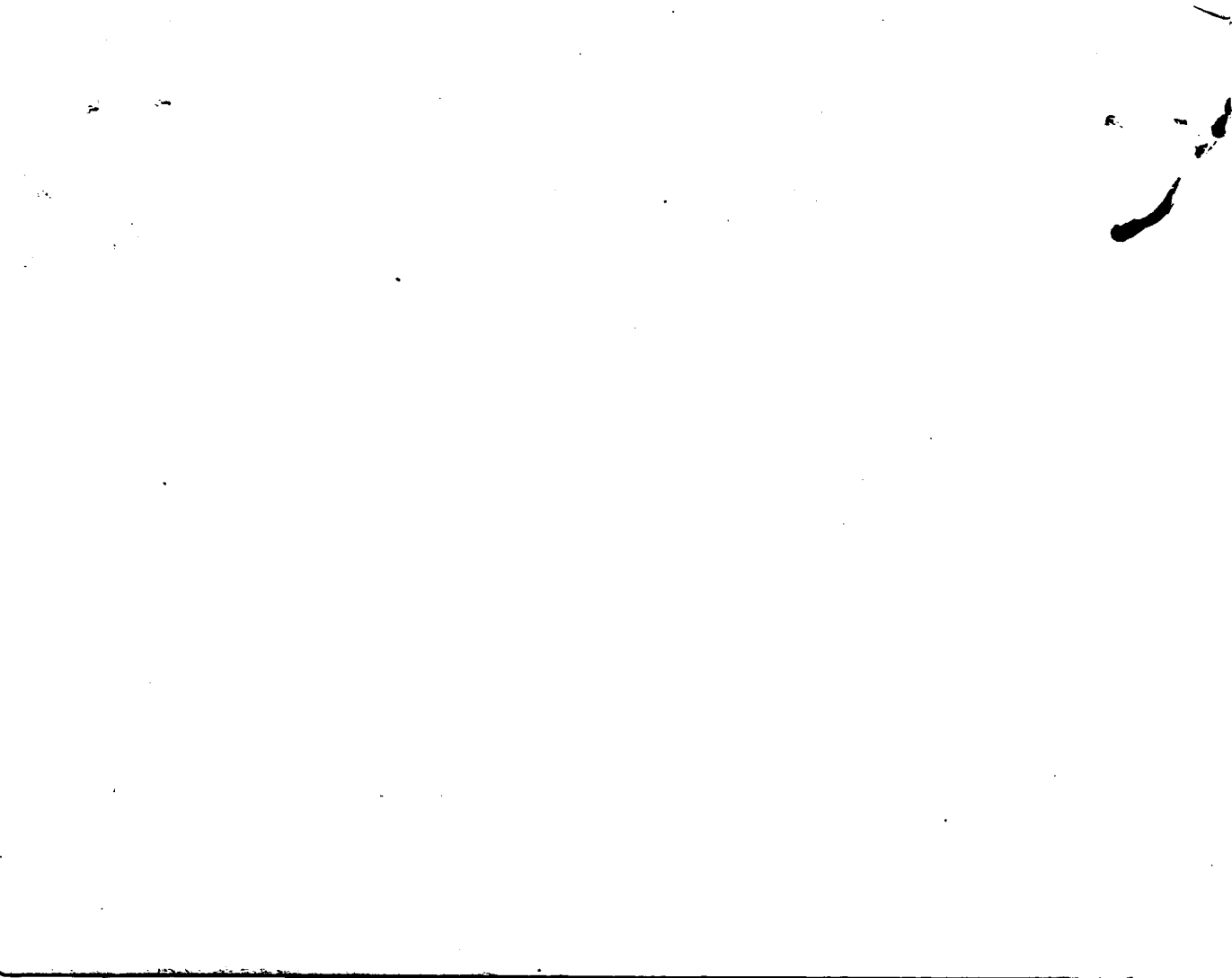
Give names added from a supplemental report.

Address Weiser, Idaho

Filed 1/11/21 1921

Registrar.

Registrar.



## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

Yrs.

Mos.

ds.

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

19

Local Registrar

## RECEIVED CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Contributory (Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

19

(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

151-2

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

318-211003-394

PLACE OF BIRTH

County of Bannock

City of Virginia

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

RECEIVED BUREAU OF

DEC 18 1921

BUREAU OF VITAL  
STATISTICS

V. S. No. 11-C-25m-7-21-19

S

96742

Primary Registration District No. 6 Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and _____	Number in order of birth _____	Legiti mate? <u>Yes</u>	Date of Birth <u>10-11-1921</u> (Month) (Day) (Year)
----------------------------	---	-----------	--------------------------------	-------------------------	---

FULL NAME <u>H. A. Taylor</u>	FATHER
RESIDENCE <u>Virginia Idaho</u>	
COLOR <u>wd</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)
BIRTHPLACE <u>Payson, Idaho</u>	
OCCUPATION <u>farmer</u>	

FULL MAIDEN NAME <u>Elizabeth Crump</u>	MOTHER
RESIDENCE <u>Virginia Idaho</u>	
COLOR <u>wd</u>	AGE AT LAST BIRTHDAY <u>34</u> (Years)
BIRTHPLACE <u>Payson, Idaho</u>	
OCCUPATION <u>wd wife</u>	

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7:00 A. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. J. Hartigson  
\_\_\_\_\_  
(Physician or midwife)

Given names added from a supplemental report.

Address Payson, Idaho  
Filed Oct 18 1921 H. J. Hartigson  
\_\_\_\_\_  
Registrar



100-443888-100

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. 36261

Registered No. \_\_\_\_\_

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## 1. PLACE OF DEATH

County of Bannock  
City of VirginiaIf death occurs away from  
usual residence, give facts  
called for under special in-  
formation.Registration District No. 83  
Primary Registration District No. 2160  
(DEC 18 1931) St. \_\_\_\_\_BUREAU OF  
STATISTICS

## 2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED Single  
(Write the word.)

## 6. DATE OF BIRTH

Oct 11 1931  
(Month) (Day) (Year)

## 7. AGE

Stillborn  
Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds. \_\_\_\_\_IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min. ?

## 8. OCCUPATION

(a) Trade, profession or  
particular kind of work \_\_\_\_\_  
(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer) \_\_\_\_\_

## 9. BIRTHPLACE

(State or Country) Virginia Idaho10. NAME OF  
FATHERW. M. Taylor11. BIRTHPLACE  
OF FATHER(State or Country) Kayville, Idaho12. MAIDEN NAME  
OF MOTHERElizabeth Crump13. BIRTHPLACE  
OF MOTHER(State or Country) Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(Address) Virginia, Idaho

## 15.

Filed Oct 11, 1931Local Registrar H. H. Boutigum

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Oct 11 1931  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from  
Oct 11, 1931, to Oct 11, 1931,  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_,  
and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Full term Stillborn

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. H. Boutigum M. D.(Address) Idaho\*State the Disease Causing Death; or in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the  
State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.Where was disease contracted  
if not at place of death? \_\_\_\_\_Former or  
usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Virginia Idaho Oct 13, 1931

## 20. UNDERTAKER

ADDRESS \_\_\_\_\_

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

✓  
-  
681

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

753-1091004-714  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

County of Bear Lake  
City of Orin  
No. 1 St. 1  
Hospital 1  
Registration District No. 52  
Primary Registration District No. 2136  
File No. 96799  
Registered No. 96799

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child Boy Twin Triplet or other? None and Number in order of birth 1 Legitimate? Yes Date of birth 12 9 1921  
(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

FATHER FULL NAME Orin Peterson RESIDENCE Orin  
MOTHER FULL MAIDEN NAME Sarah C. Paulsen RESIDENCE Orin

COLOR W AGE AT LAST BIRTHDAY 23 (Years)  
COLOR W AGE AT LAST BIRTHDAY 24 (Years)

BIRTHPLACE Orin BIRTHPLACE Idaho

OCCUPATION Farmer OCCUPATION Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at Orin, M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Dr. V. C. Paulsen

Physician Montpelier Idaho  
(Physician or midwife)

Address 12-10-1

Filed 12-10-1 1921 Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

123-111-204-384  
PLACE OF BIRTH

RECEIVED

DEC 18 1921

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of *Bear Lake*

City of *Bennington*

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

No. \_\_\_\_\_

St. \_\_\_\_\_

Registration District No. *52*

File No. *S 96803*

Hospital \_\_\_\_\_

Primary Registration District No. *2136*

Registered No. \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

(Certificate of no value without full name of child.)

Sex of Child *Boy*

Twin  
Triplet  
or other?

and

Number  
in order  
of birth

Legiti-  
mate? *yes*

Date of  
birth *12 11*

(Month)

(Day)

1921  
(Year)

What bactericide solution was used in eyes? *✓*

Number of child of this mother, including present birth... *2*

Number of children of this mother now living, including present birth... *2*

FULL  
NAME

FATHER

FULL  
MAIDEN  
NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR *W*

AGE AT LAST  
BIRTHDAY *31*

(Years)

COLOR *W*

AGE AT LAST  
BIRTHDAY *38*

(Years)

BIRTHPLACE *Bennington*

BIRTHPLACE *Captain*

OCCUPATION *Farmer*

OCCUPATION *Musician*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was born on the date above stated.

(Born alive or stillborn)

M.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *W. J. Kelley*

(Physician or midwife)

Give names added from a supplemental report.

Address *Montpelier Idaho*

Filed *12-15*

1921

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

415-213-001-133  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

RECEIVED  
JAN 10 1922  
BUREAU OF VITAL  
CERTIFICATE OF BIRTH S96866

County of Ada  
City of Boise  
No. 1726 Fairview St. Register District No. 2 File No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 1004 Registered No. 538  
FULL NAME OF CHILD William Zella Manning  
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Dec 13</u> 192 <u>1</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------------	--

What bactericidal solution was used in eyes? None  
Number of child of this mother, including present birth. 1 Number of child of this mother now living, including present birth. 0

FATHER  
FULL NAME Samuel W Manning  
RESIDENCE Boise Idaho  
COLOR White AGE AT LAST BIRTHDAY 44 (Years)  
BIRTHPLACE Illinois  
OCCUPATION Second hand dealer

MOTHER  
FULL MAIDEN NAME Sussie Allan  
RESIDENCE Boise Idaho  
COLOR White AGE AT LAST BIRTHDAY 27 (Years)  
BIRTHPLACE Kansas  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING

I hereby certify that I attended the birth of this child, who was on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

OR MIDWIFE\* Joseph B Ward at 915 a M.  
(Born alive or stillborn)  
(Signature) \_\_\_\_\_  
(Physician or midwife)  
Address \_\_\_\_\_  
Filed 12 \_\_\_\_\_  
Registrar. R. H. Pratt

Give names added from a supplemental report.  
\_\_\_\_\_, 19\_\_\_\_  
Registrar.

DEPARTMENT OF PUBLIC WORKS

Registration

CHIEF

CLERK



Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place { City Boise, Idaho. File Number 96866  
 of { Street 1796 Fairview ave.  
 Birth { County Ada. Registration Dist. No. Park school  
 Sex of Child Female Date of Birth Dec. 13. 192.  
 Father Samuel Walter Manning Mother Susie Allen nee M.  
 Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Ruby Gella Manning.  
 Child's Name in Full

Mrs. S. W. Manning.  
 Signature of Father or Mother

rt-  
ow

ol.

1.

anning



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 36504  
Registered No. 361

## 1. PLACE OF DEATH

County of Ada  
City of Boise

RECEIVED

JAN 1

BUREAU

STA.

Registration District No. 2  
Primary Registration District No. 1204  
(No. 1726, Fairview Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Manning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

F.

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

## 6. DATE OF BIRTH

Dec 13

(Month)

(Day)

1921  
(Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs.  
or min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Samuel W. Manning

## 11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

## 12. MAIDEN NAME OF MOTHER

Lucie Allen

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel W. Manning

(Address)

## 15.

Filed Dec 13 1921

R. A. Pratt  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec 13

(Month)

(Day)

1921  
(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on 19

and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH\* was as follows:

Still born

(Duration)

Yrs.

mos.

ds.

Contributory  
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

Roscoe B. Ward

M. D.

12/13 1921

(Address)

Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem

## DATE OF BURIAL

19

## 20. UNDERTAKER

Sumner & Sells

## ADDRESS

Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. E.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

249-128-014-364  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S97106

County of Sanborn RECEIVED  
City of Melba JAN 10 1922  
No. \_\_\_\_\_ St. \_\_\_\_\_ Registration District No. \_\_\_\_\_  
Hospital \_\_\_\_\_ Primary Registration District No. 2006 File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
FULL NAME OF CHILD Valley Burton  
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and {	Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Nov 28</u> 1921 (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth... 6 Number of child of this mother now living, including present birth... 4

FATHER		MOTHER	
FULL NAME	<u>Wallace Mill Burton</u>	FULL MAIDEN NAME	<u>Katherine Cook</u>
RESIDENCE	<u>Melba, Id.</u>	RESIDENCE	<u>Melba, Id.</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>41</u> (Years)	AGE AT LAST BIRTHDAY	<u>36</u> (Years)
BIRTHPLACE	<u>Wisconsin</u>	BIRTHPLACE	<u>Wisconsin</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was... still born ... at... 5 ... P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Daniel A. Swaine  
Melba, Id.  
(Physician or midwife)

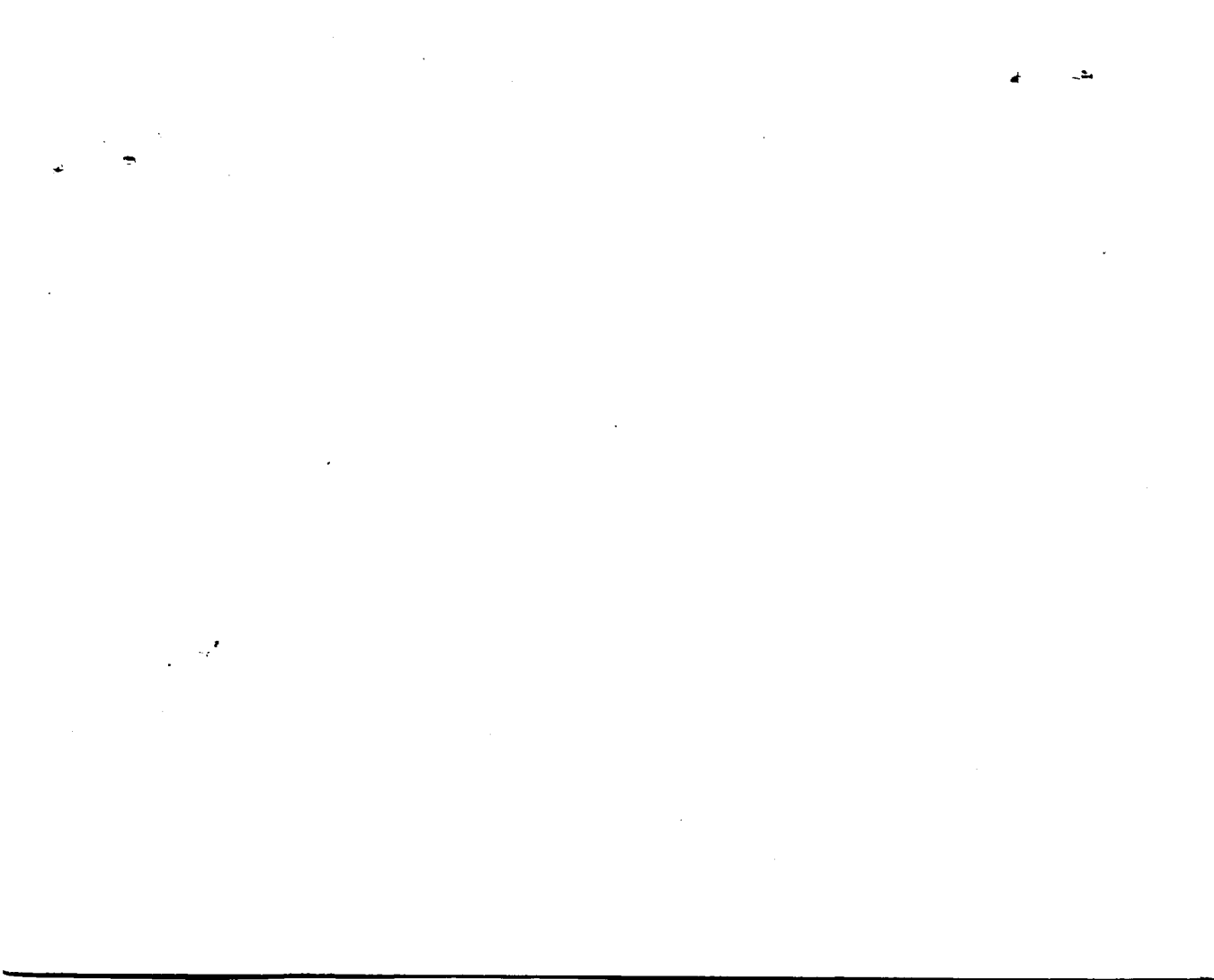
Give names added from a supplemental report.

Address

Filed

Dec 13 1921 Leah D. D. D.  
Registrar.

Registrar.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital StatisticsFile No. 36401  
Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## 1. PLACE OF DEATH

Registration District No. \_\_\_\_\_

County of \_\_\_\_\_

Primary Registration District No. 200

City of \_\_\_\_\_

(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Burton

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

Nov.  
(Month)28  
(Day)1921  
(Year)

## 7. AGE

0 Yrs. 0 Mos. 0 ds.IF LESS than 1 day  
how many 0 hrs.  
or 0 min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

Ada Co., Idaho

## 10. NAME OF FATHER

Wallace M. Burton

## 11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

## 12. MAIDEN NAME OF MOTHER

Ratherine Cook

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wallace M. Burton

(Address)

714 E. 2nd

## 15.

Filed Dec 2 1921

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Nov.  
(Month)28  
(Day)1921  
(Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Nov 28 1921, to Nov 28 1921,

that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_,

and that death occurred on the date stated above, at 7 M.

The CAUSE OF DEATH\* was as follows:

Still birth - macerated fetus  
7 months intra uterine gestation

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

S. A. Swaine M. D.Dec 3 1921 (Address) Melba, Id

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

MelbaDec 28 1921

## 20. UNDERTAKER

## ADDRESS

none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

719-117-014-285

PLACE OF BIRTH

STATE OF IDAHO  
VITAL STATISTICS

Form V. S. No. 11-C-25m-7-21-19

County of Canyon  
City of Nampa  
No. R. # 5

RECEIVED  
JAN 10 1922  
BUREAU OF VITAL STATISTICS

DATE OF BIRTH

S 97115

File No.

Primary Registration District No. 1006

Registered No.

Hospital

FULL NAME OF CHILD

Parker

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti mate?	Date of Birth	<u>Dec- 17</u>	<u>19 21</u>
				<u>Yes</u>	(Month)	(Day)	(Year)

FATHER  
FULL NAME Thos. G. Parker  
RESIDENCE Nampa  
COLOR White AGE AT LAST BIRTHDAY 36 (Years)  
BIRTHPLACE Alabama  
OCCUPATION Barber

MOTHER  
FULL MAIDEN NAME Margaret B. Shepherd  
RESIDENCE Nampa  
COLOR White AGE AT LAST BIRTHDAY 36 (Years)  
BIRTHPLACE Utah  
OCCUPATION Housewife

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 10 P.M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. O. R. Proctor  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Filed Jan. 10 1922 Pearle Dodds  
Registrar

Registrar





FORM V. S. No. 5-A—25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Canyon  
City of NampaRegistration District No. 7Primary Registration District No. 1006

(No. .... St.)

File No. 36399  
Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant Parker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCEDMale White

(Write the word.)

## 6. DATE OF BIRTH

Dec. 17 1922  
(Month) (Day) (Year)

## 7. AGE

X

Yrs. .... Mos. .... ds.

IF LESS than 1 day  
how many .... hrs.  
or .... min.?8. OCCUPATION X(a) Trade, profession or particular kind of work.  
(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Nampa Ida.

## 10. NAME OF FATHER

Thos. G. Parker

## 11. BIRTHPLACE OF FATHER

(State or Country)

Alabama

## 12. MAIDEN NAME OF MOTHER

Margaret B. Shepherd

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

## 15.

Filed Jan. 10 1923Pearle A. ...  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec. 17 1922  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Dec 17 1922, to Jan 19  
that I last saw him alive on 19  
and that death occurred on the date stated above, at M.  
The CAUSE OF DEATH\* was as follows:Premature, cephalic

(Duration) .... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) .... Yrs. .... mos. .... ds.

(Signed)

Geo. R. Parker M. D.

(Address) .....

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Nampa Dec 17 1922

## 20. UNDERTAKER

## ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

962-212-016-653

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 97138

County of CassiaCity of BurleyRegistration District No. 117

File No.

No. \_\_\_\_\_ St.

Primary Registration District No. 2196Registered No. 2151

Hospital \_\_\_\_\_

## FULL NAME OF CHILD

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth _____	Legitimate? <u>yes</u>	Date of Birth <u>12 12 1921</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

FATHER  
FULL NAME Wm H RobertsRESIDENCE BurleyCOLOR WhiteAGE AT LAST BIRTHDAY 37  
(Years)BIRTHPLACE IdahoOCCUPATION LabourMOTHER  
FULL MAIDEN NAME Rosetta WelkerRESIDENCE BurleyCOLOR WhiteAGE AT LAST BIRTHDAY 32  
(Years)BIRTHPLACE IdahoOCCUPATION KnifNumber of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 5

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born dead, at 3 40 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) F H Center(Physician or midwife) M.D.

Given names added from a supplemental report.

19

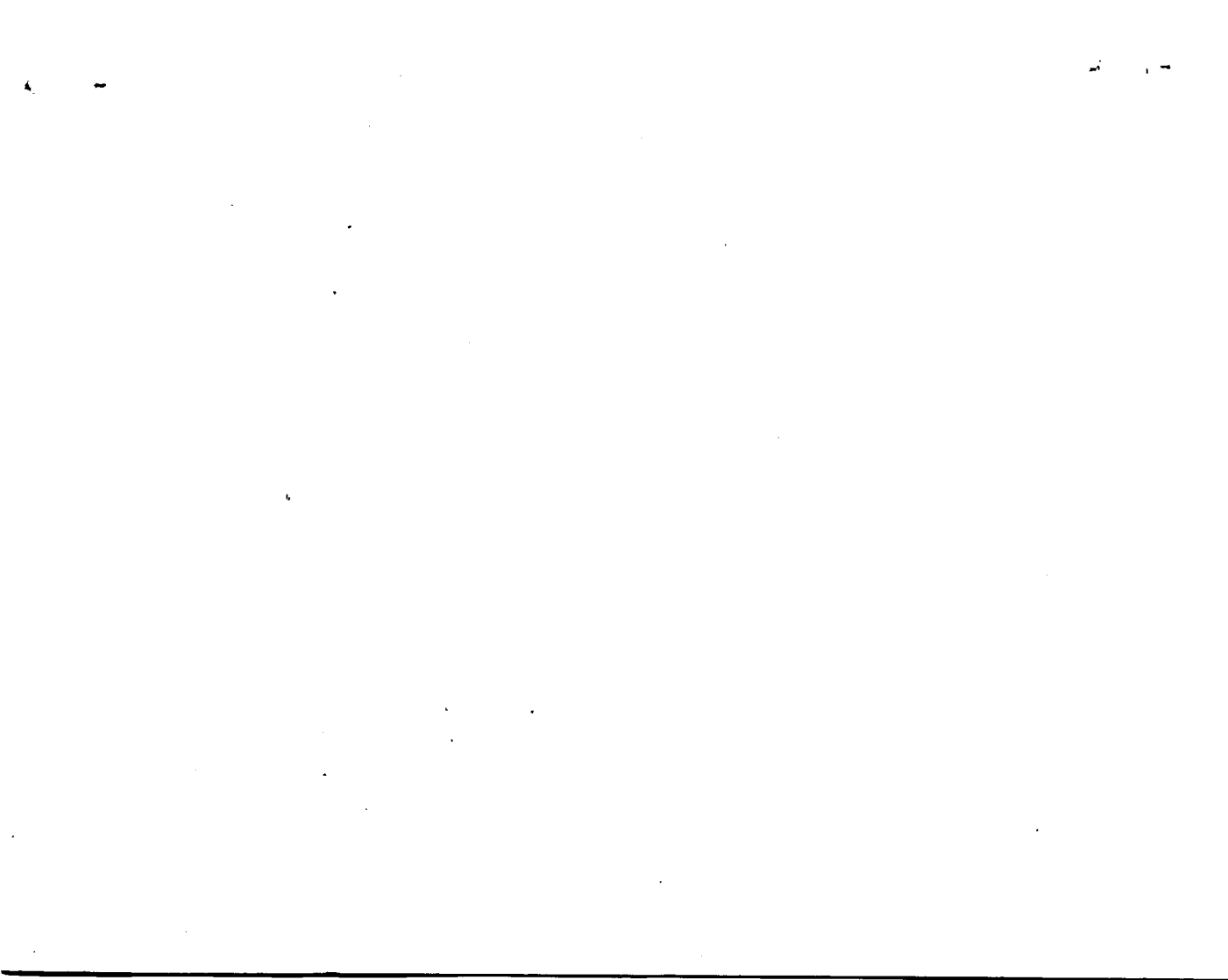
Address BurleyFiled Jan 5th 19 22

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 36403  
Registered No. 338

## 1. PLACE OF DEATH

County of Cassia Registration District No. 117  
City of Burley Primary Registration District No. 2196  
If death occurs away from usual residence, give facts called for under special information. BUREAU OF VITAL STATISTICS  
2. FULL NAME Baby Roberts (St.)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH Dec. 12-21-1911  
(Month) (Day) (Year)

7. AGE Still Born IF LESS than 1 day how many hrs. or min.?  
Yrs. Mos. ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Burley Ida

## 10. NAME OF FATHER

William C. Roberts

## 11. BIRTHPLACE OF FATHER

(State or Country) Cokeville Wyoming

## 12. MAIDEN NAME OF MOTHER

Rosetta Welker

## 13. BIRTHPLACE OF MOTHER

(State or Country) Bloomington Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Roberts  
(Address) 311 N. Molta Ave. Burley Ida.

15. Jan 5th 1912  
Filed Jan 5th 1912  
H. J. Patterson  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec. 12-21-1911  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Dec. 12-21-1911 to Dec. 12-21-1911

that I last saw him alive on Dec. 12-21-1911

and that death occurred on the date stated above, at Dec. 12-21-1911 M.

The CAUSE OF DEATH\* was as follows:

Still Born  
(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) F. H. Cutler M. D.

Burley  
(Address)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the  
of death yrs. mos. days. State yrs. mos. days

Where was disease contracted  
if not at place of death?

Former or  
usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Burley Ida.

## DATE OF BURIAL

12/12/1911

## 20. UNDERTAKER

L. B. Goleggy

## ADDRESS

Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation) using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"), *Lobar pneumonia*, *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoncum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms, *Measles; Whooping cough; Chronic valvular heart disease; Chronic intestinal nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*," "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

235-113-016-236

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 97140

County of CassiaCity of BurleyRegistration District No. 117

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2196Registered No. 2153FULL NAME OF CHILD Baby Stephens Cora

Sex of Child

MaleTwin  
Triplet  
or other?  
(To be answered only in event of plural births)

and

Number  
in order  
of birthLegiti  
mate?YesDate of  
Birth12131921

(Month)

(Day)

(Year)

FULL  
NAMEEdw A Stephens

FATHER

RESIDENCE

Burley

COLOR

WhiteAGE AT LAST  
BIRTHDAY43  
(Years)

BIRTHPLACE

Utah

OCCUPATION

FarmerFULL  
MAIDEN  
NAMEMary Stone

MOTHER

RESIDENCE

Burley

COLOR

WhiteAGE AT LAST  
BIRTHDAY32  
(Years)

BIRTHPLACE

Utah

OCCUPATION

ProfNumber of child of this mother, including present birth 8 Number of children of this mother now living, including present birth 6

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was born dead, at 11 a.m. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

F H Cutler  
MD

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Burley Ida

Filed

Jan 5th 1922 Dr. J. C. Patterson

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

# OHIO TO STATE

BRANDED WITH THE MARK OF THE

STATE OF OHIO



RECEIVED  
FEB 25 1922  
BUREAU OF VITAL  
STATISTICS

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho, ..... JAN 17 1922 ..... 192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City Burley .....  
Street .....  
County Basia .....  
Sex of Child Male .....  
Date of Birth Dec 13 ..... 1922.  
Father Edmond A. Stephens .....  
Mother Mary Stone .....  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Cora Stephens .....  
Child's Name in Full

Mrs E A Stephens .....  
Signature of Father or Mother



465-224-021-843

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

RECEIVED STATE OF IDAHO  
BUREAU OF VITAL STATISTICSCounty of FranklinJAN 10 1922  
CERTIFICATE OF BIRTH

S

City of MestonBUREAU OF VITAL STATISTICS  
Registration District No. 27 File No. 97196

No. \_\_\_\_\_ St.

Primary Registration District No. 2119 Registered No. 255

Hospital \_\_\_\_\_

## FULL NAME OF CHILD

Ruby Savoy Mornon

Sex of Child <u>Female</u>	Twin Triplet or other? _____	and _____	Number in order of birth <u>6</u>	Legitimate? <u>yes</u>	Date of Birth <u>Dec 24</u> 19 <u>21</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

FULL NAME FATHER Mantell H. MansonFULL MAIDEN NAME MOTHER Ethel May KulseRESIDENCE Near Meston IdahoRESIDENCE Near MestonCOLOR White AGE AT LAST BIRTHDAY 23 (Years)COLOR White AGE AT LAST BIRTHDAY 33 (Years)BIRTHPLACE Wyoming StateBIRTHPLACE Kansas City MoOCCUPATION FarmerOCCUPATION HousekeeperNumber of child of this mother, including present birth 6 Number of children of this mother now living, including present birth 5

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 1 20 P M. on the date above stated.

(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Thos B. Halper  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

19

Address

Meston Idaho  
Jan 4 1922 A. R. Cutler  
Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WORKS ARE

## STATE OF IDAHO

## DEPARTMENT OF PUBLIC WELFARE

RECEIVED

JAN 23 1922

VITAL

Boise, Idaho,.....JAN 17 1922.....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

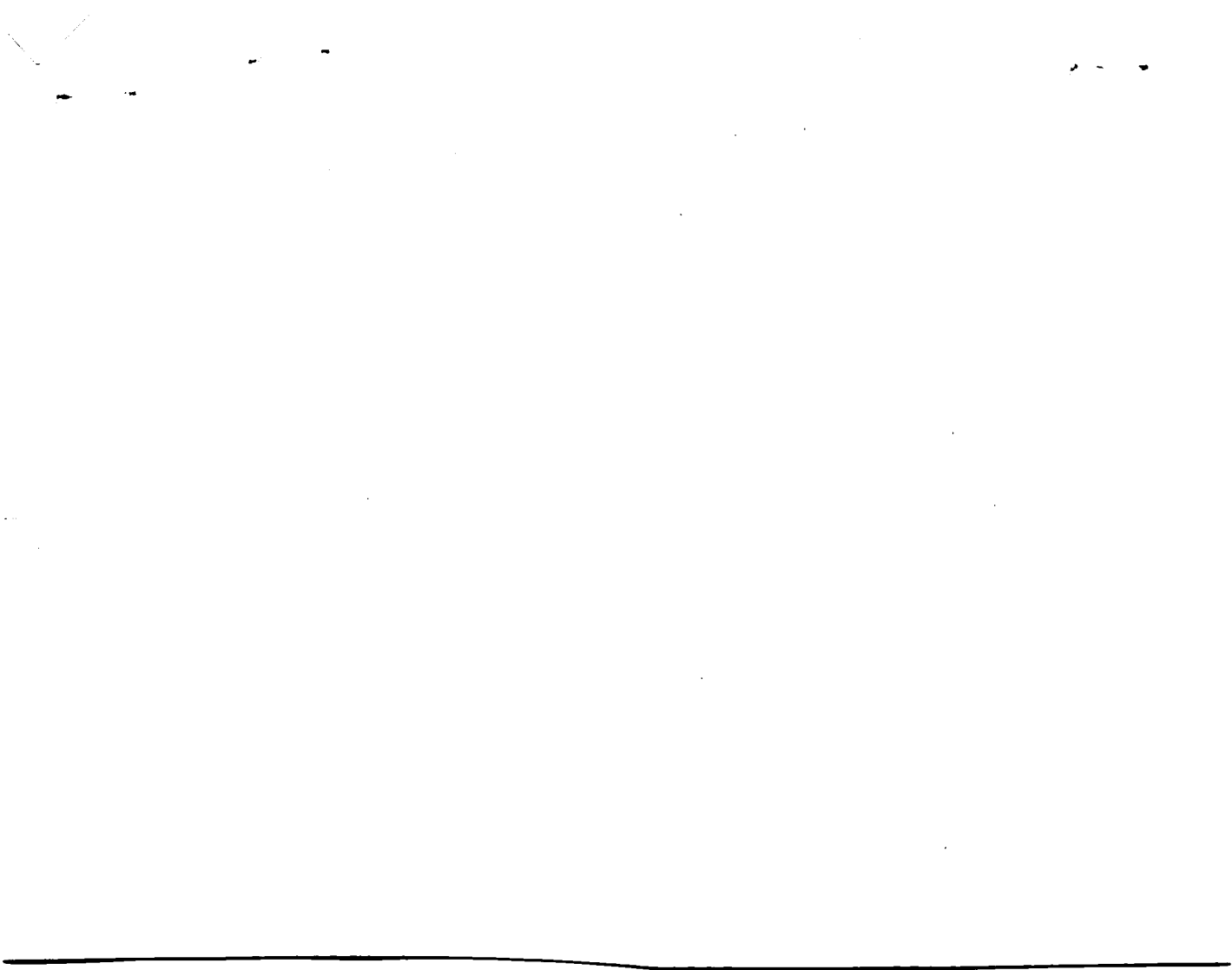
BUREAU OF VITAL STATISTICS.

Place of Birth { City *Weston* .....  
 Street .....  
 County *Franklin* .....  
 File Number *97196* .....  
 Registration Dist. No. *17* .....  
 Date of Birth *Dec 24* ..... 1921...  
 Sex of Child *Female* .....  
 Father *Grantell Henry Monson* ..... Mother *Ethel May Fulse* .....  
 Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

*Rubin Le Roy Monson* .....  
 Child's Name in Full

*Grantell H. Monson* .....  
 Signature of Father or Mother



## 1. PLACE OF DEATH

County of Franklin Registration District No. 27  
 City of Wooten Primary Registration District No. 2119  
 St. Idaho

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Stillborn

## CERTIFICATE OF DEATH

36417

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. ....

Registered No. 69

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX 2 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-  
 OWED OR DIVORCED single  
 (Write the word.)

6. DATE OF BIRTH Dec 24 1921  
 (Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day  
 how many — hrs.  
 or — min. ?  
0 Yrs. 0 Mos. 0 ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work. none  
 (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Wooten Ida.

## 10. NAME OF FATHER

Walter H. Monson

## 11. BIRTHPLACE OF FATHER

(State or Country) Utah

## 12. MAIDEN NAME OF MOTHER

Ethel May Hulse

## 13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion Anderson  
 (Address) Wooten Ida

15. Filed Jan 4 1922 M. P. Butler Jr.  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec 24 1921  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19 to 19  
 that I last saw her head Dec 24 1921  
 and that death occurred on the date stated above, at M.

## The CAUSE OF DEATH\* was as follows:

This Baby was still born

(Duration) Yrs. mos. ds.

## Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos B Holder M. D.19 (Address) Wooten

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wooten, Idaho Dec 25 1921

## 20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."



769-127-026-369

PLACE OF BIRTH

Form V. S. No. 11-20m-7-24-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Jefferson VITAL CERTIFICATE OF BIRTH  
City of Rigby Registration District No. 98 File No. 97339  
No. \_\_\_\_\_ St. \_\_\_\_\_ Primary Registration District No. 2176 Registered No. 4  
Hospital \_\_\_\_\_

FULL NAME OF CHILD \_\_\_\_\_

Sex of Child M Twin Yes and (Number in order of birth 2nd) Legitimate? yes Date of Birth 12-27-21  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Don Gordon  
RESIDENCE Rigby  
COLOR W AGE AT LAST BIRTHDAY 31  
(Years)  
BIRTHPLACE Okla  
OCCUPATION Labourer

MOTHER  
FULL MAIDEN NAME Emily Gordon  
RESIDENCE same  
COLOR W AGE AT LAST BIRTHDAY 28  
(Years)  
BIRTHPLACE Idaho  
OCCUPATION at home

Number of child of this mother, including present birth 7 Number of children of this mother now living, including present birth 4

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was  
on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

(Signature)

Born dead 4:20 a.m.  
(Born alive or stillborn)  
Ray H. Fisher  
(Physician or midwife)

Address

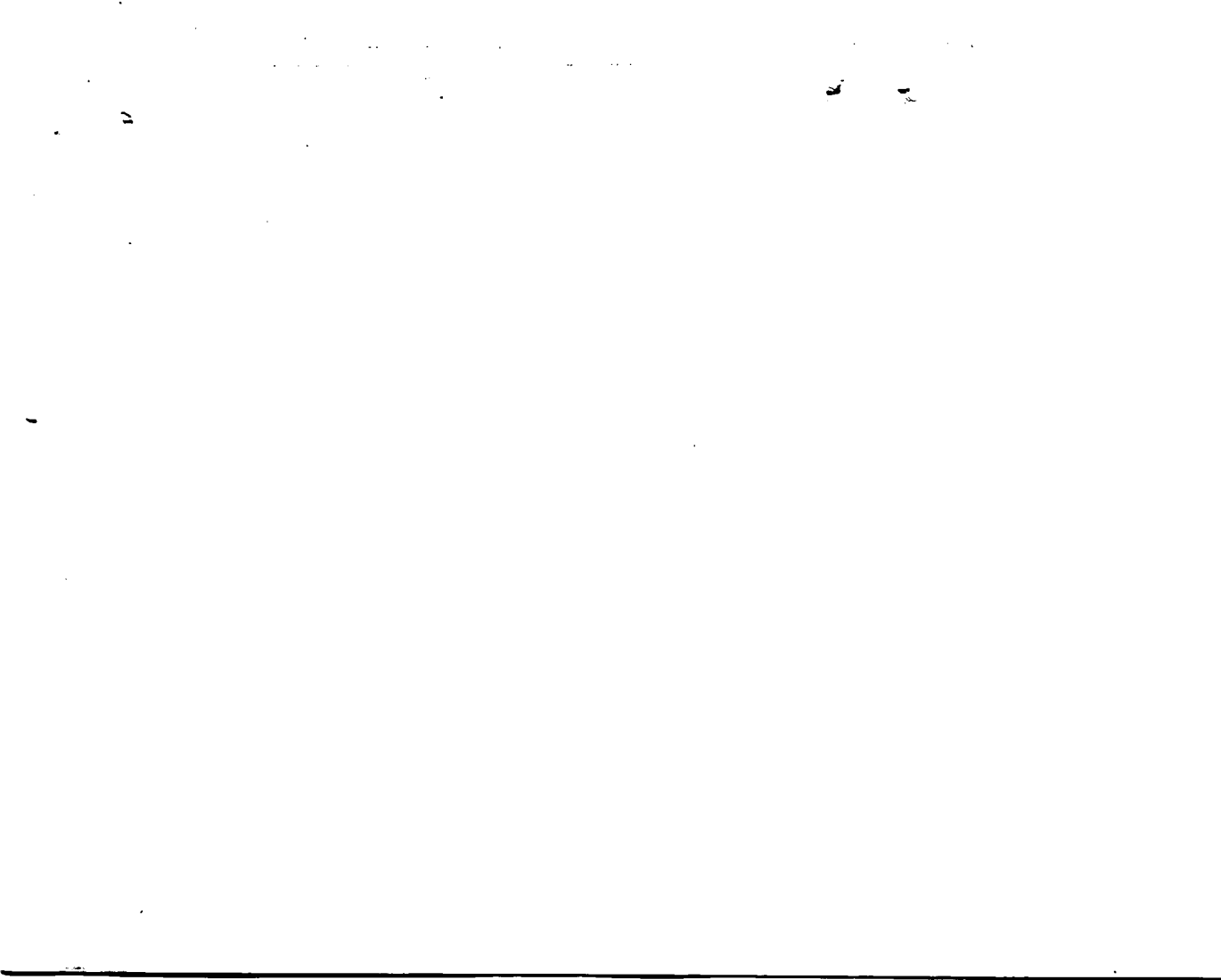
Filed

Registrar.

Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Registration District No.

BUREAU OF VITAL STATISTICS

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day  
how many hrs.  
or min.?

8. OCCUPATION

(a) Trade, profession or  
particular kind of work.(b) General nature of in-  
dustry, business or estab-  
lishment in which employ-  
ed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF  
FATHER11. BIRTHPLACE  
OF FATHER

(State or Country)

12. MAIDEN NAME  
OF MOTHER13. BIRTHPLACE  
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Contributory  
(Secondary)

(Signed)

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted  
if not at place of death?Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

363-113-038-236

PLACE OF BIRTH

RECEIVED

JAN 10 1922

STATE OF IDAHO

Form V-9. No. 44-25-4-15-18

County of PayetteBUREAU OF VITAL  
STATISTICS

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

City of New Plymouth

S 97554

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. 5

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2009Registered No. 46Full Name of Child Jack C. CollinsworthSEX OF  
CHILDmTwin  
Triplet  
or other?  
(To be answered only in event of plural births){ and } Number  
in order  
of birth  
(To be answered only in event of plural births)Legiti-  
mate?yesDATE OF  
BIRTHNov 13  
(Month) (Day) (Year)FULL  
NAMEChester C. Collinsworth

FATHER

FULL  
MAIDEN  
NAMEAnnie Stone

MOTHER

RESIDENCE

New Plymouth Ida

RESIDENCE

with husband

COLOR

rrAGE AT LAST  
BIRTHDAY37

(Years)

COLOR

rrAGE AT LAST  
BIRTHDAY30

(Years)

BIRTHPLACE

Kans

BIRTHPLACE

Mo

OCCUPATION

Farmer

OCCUPATION

Housewife

Number of child of this mother, including present birth..... Number of children of this mother now living, including present birth.....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn, at 6 P. M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Wm J. Drysdale M.D.

(Physician or midwife)

Given names added from a supplemental report

Address New Plymouth IdaFiled Wm J. Drysdale

Registrar

Registrar

N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

ON here

RECEIVED

304101238

NOTES

204 JANTRID

000094014

CERTIFICATE OF ADOPTION FIRST DAY OF MARCH

(The date above stated)

1. (b)  $\frac{1}{2}$

(show) a 20 mg/100 cc

.....

.. 11 .....

18721508

# STATE OF IDAHO

RECEIVED DEPARTMENT OF PUBLIC WELFARE

FEB 18 1922

BUREAU OF VITAL STATISTICS

Boise, Idaho,..... JAN 17 1922..... 192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

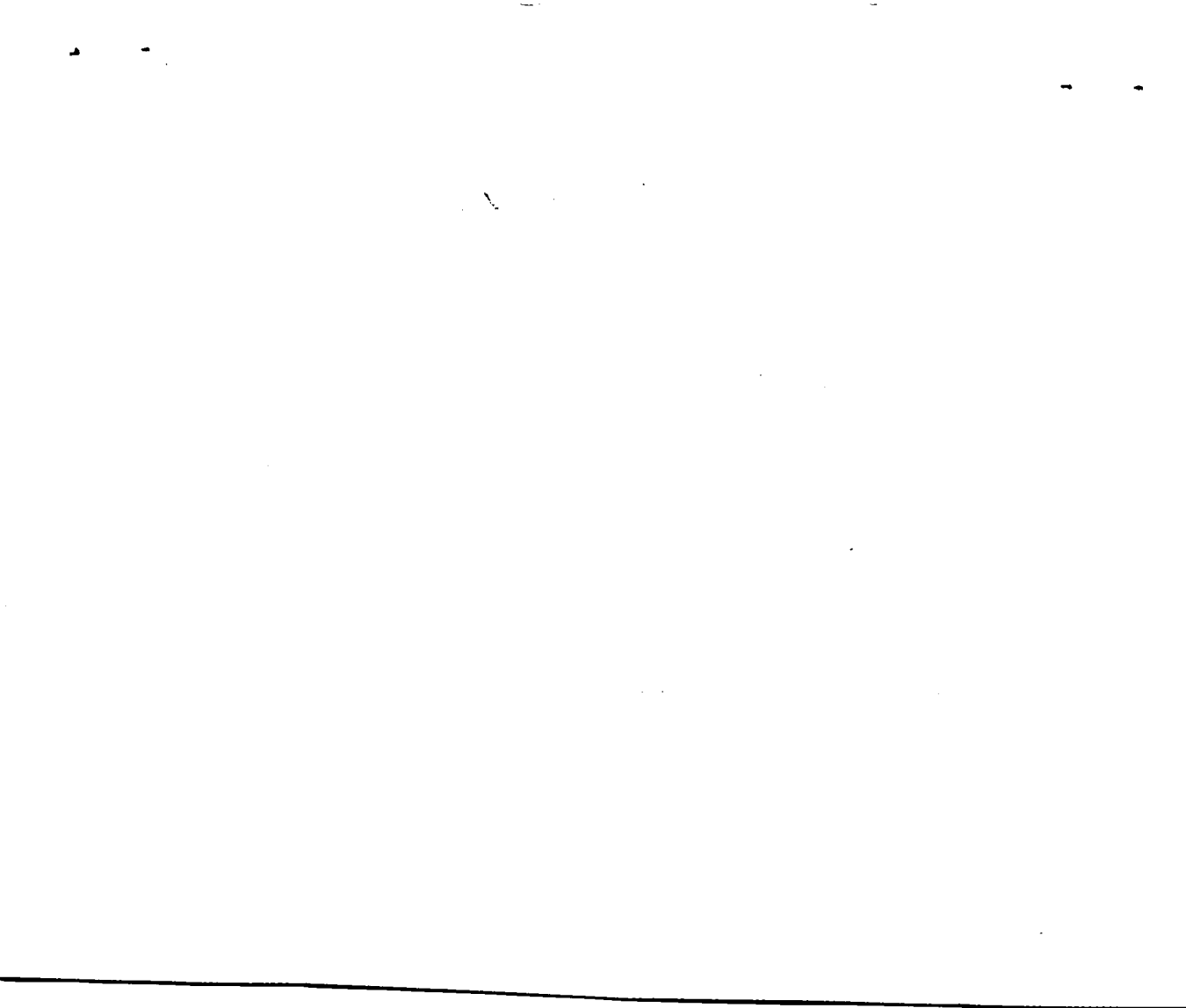
BUREAU OF VITAL STATISTICS.

Place { City *New Plymouth*..... File Number .....97554.....  
 of { Street .....  
 Birth { County *Lapwai*.....  
 Sex of Child.....Male..... Date of Birth *Nov. 13*.....1921/...  
 Father *Chester Cleveland Collinsworth*..... Mother *Anice Elsie Stone*.....  
 Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

.....*Jack C. Collinsworth*.....  
 Child's Name in Full

.....*Nov 13 1921*.....  
 Signature of Father or Mother





MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH Passaic Registration District No. 5  
County of Passaic Registration District No. 2009  
City of New Plymouth (St.)

File No. 36500

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Collinsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant  
(Write the word.)

6. DATE OF BIRTH Nov 13 1921  
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Ida  
(State or Country)

10. NAME OF FATHER Chester C Collinsworth

11. BIRTHPLACE OF FATHER Kan  
(State or Country)

12. MAIDEN NAME OF MOTHER Annie Slone

13. BIRTHPLACE OF MOTHER Ind  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Wm Linder  
(Address) New Plymouth Ida

15. Filed Nov 14 1921 Wm Linder  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 13 1921  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth to 1921, that I last saw him alive on 1921, and that death occurred on the date stated above, at M. The CAUSE OF DEATH\* was as follows:

eclampsia in mother  
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.  
(Signed) Wm Linder M. D.

11-14 1921 (Address) New Plymouth

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Nov 14 - New Plymouth Ida DATE OF BURIAL 1921

20. UNDERTAKER Father J Child ADDRESS New Plymouth

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK - THIS IS A PERMANENT RECORD  
N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

319-223-040-168

PLACE OF BIRTH Idaho **RECEIVED** STATE OF IDAHO **Form V. S. No. 11-C-25m-3-3-37**  
 County of Shoshone **JAN 10 1922** BUREAU OF VITAL STATISTICS  
 City of Kellogg **123** **CERTIFICATE OF BIRTH**  
 Registration District No. 123 File No. **S 97584**  
 No. ..... St. ..... Primary Registration District No. ..... Registered No. 68  
 Hospital ..... **Still Born Baby Larson**  
 FULL NAME OF CHILD .....

Sex of Child <u>Female</u>	Twin Triplet or other? <u>.....</u> and Number in order of birth <u>2</u>	Legitimate? <u>yes</u>	Date of Birth <u>11</u> <u>23</u> <u>1912</u> (Month) (Day) (Year)
FULL NAME FATHER <u>Thos Larson</u>		FULL MAIDEN NAME MOTHER <u>Anna Johnson</u>	
RESIDENCE <u>Kellogg Ida</u>		RESIDENCE <u>Kellogg Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>36</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>Norway</u>		BIRTHPLACE <u>Sweden</u>	
OCCUPATION <u>Painter</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

**CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\***

I hereby certify that I attended the birth of this child, who was Stillborn at 10 ..... M.  
 on the date above stated. (Born alive or stillborn)

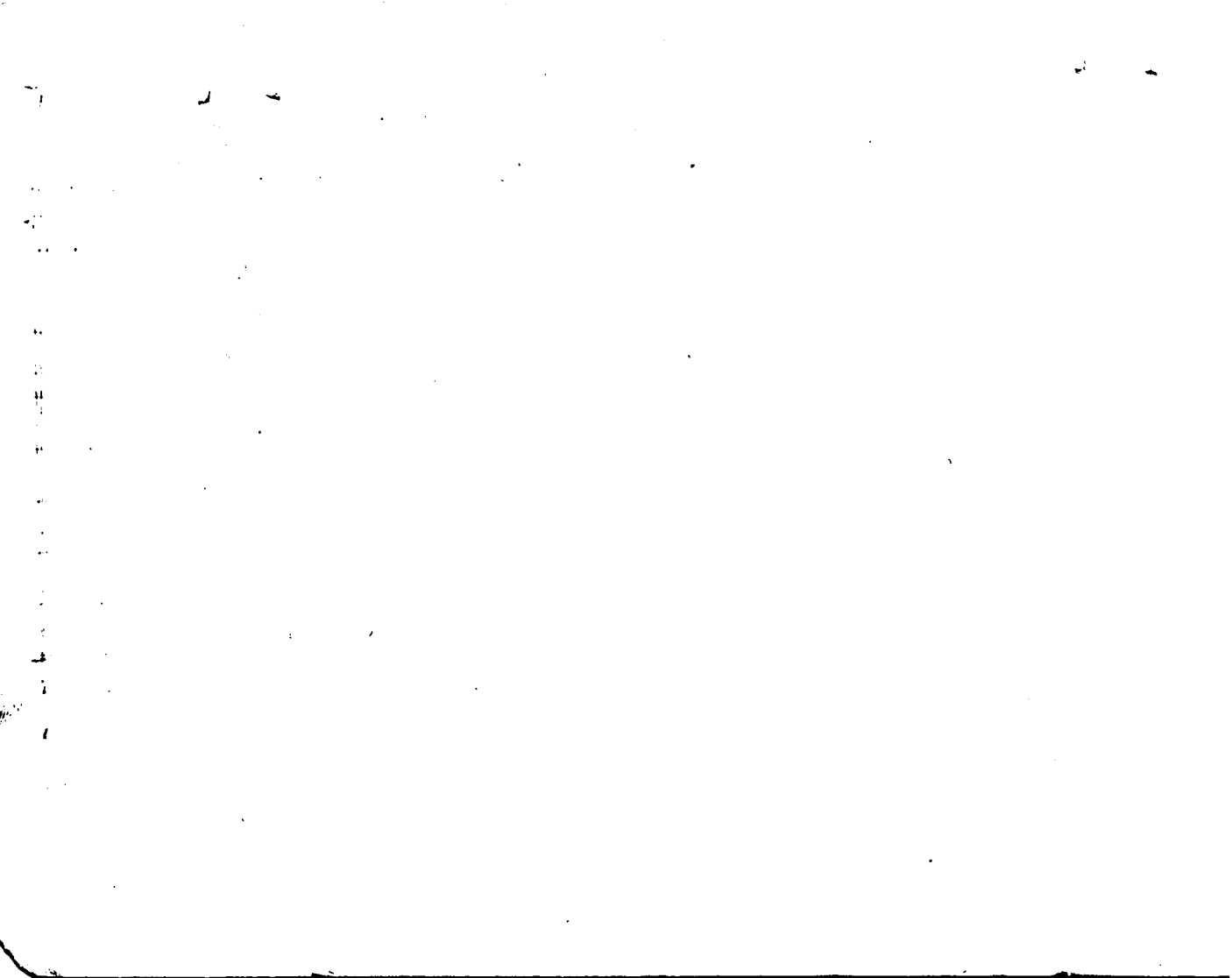
\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. C. Lloyd  
Physician  
 (Physician or midwife)

Given names added from a supplemental report.

Address Kellogg Ida

Filed 12/27/22 E. E. Hardy  
 Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

JAN 14 1922

Registration District No. 123

County of Shoshone

BUREAU OF VITAL STATISTICS

Registration District No.

City of Kellogg

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Larson

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No.

26507

Registered No.

37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

female

white

(Write the word.)

6. DATE OF BIRTH.

11 (Month)

23 (Day)

1921 (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many hrs. or min. 2

8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kellogg Ida.

10. NAME OF FATHER

Thos Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Emma Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

12/30/21

1921

E. E. Hardy

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 (Month)

23 (Day)

1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191....., to

191.....

that I last saw her alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. C. Richards

M. D.

12/19/21 (Address) Kellogg Ida.

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, Idaho

Nov. 24 1921

20. UNDERTAKER

M. C. Thacker

ADDRESS

Kellogg, Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

295-102  
001-363P

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of Blaine

CERTIFICATE OF BIRTH

City of Baie

Registration District No. 2

File No. 97676

No. St Lukes Hosp.

Primary Registration District No. 1004 Registered No. 39

Hospital St Lukes

FULL NAME OF CHILD

Sex of Child <u>M.</u>	Twins Triplet or other? <u>and</u> Number in order of birth <u>1</u>	Legit mate? <u>yes</u>	Date of Birth <u>12</u> <u>1921</u> (Month) (Day) (Year)
------------------------	--	------------------------	---

FATHER  
FULL NAME James G. King  
RESIDENCE Baie Idaho  
COLOR W. AGE AT LAST BIRTHDAY 21 (Years)  
BIRTHPLACE Oregon  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Pearl Calloway  
RESIDENCE Baie Idaho  
COLOR W. AGE AT LAST BIRTHDAY 21 (Years)  
BIRTHPLACE Mo.  
OCCUPATION Hom.

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 2:30 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mallen Calloway  
Physician  
(Physician or midwife)

Given names added from a supplemental report.

Address Baie Idaho  
Filed Jan 24 1922 R. H. Pratt  
Registrar





FORM V. S. No. 8-25 M. 1-19.

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

Registration District No. 2  
County of Ada Primary Registration District No. 1004  
City of Boise (No. Shuker Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 36310  
Registered No. 349

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED  
JAN 10 1921  
VITALFULL NAME Infant Kling

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

m. | white. | Single (Write in plain words.)

6. DATE OF BIRTH

Dec 2 1921  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Lewis C. Kling

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Pearl J. M. Colm.

13. BIRTHPLACE OF MOTHER

(State or Country)

mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Schabo

(Address)

Boise Idaho

15.

Filed Dec 2 1921R. H. Pratt  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 2 1921  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec. 5 1921, to Dec. 1 1921,that I last saw him alive on Dec. 1 1921,and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH\* was as follows:

none

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) M. Allen Galloway M. D.123 1921 (Address) Boise Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

Morris Stier | Dec 3 1921

20. UNDERTAKER | ADDRESS

Summers & Schabo | Boise Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1. PLACE OF BIRTH  
County of Canyon  
City of \_\_\_\_\_  
No. \_\_\_\_\_ St. \_\_\_\_\_

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 97767

Registration District No. \_\_\_\_\_ State File No. \_\_\_\_\_

Prim. Registration District No. \_\_\_\_\_ Local Registrar's No. \_\_\_\_\_

(If born in hospital or institution give name.)

2. FULL NAME OF CHILD Reed

3. Sex	If plural births { 4. Twin, triplet, or other _____ 5. Number, in order of birth _____	6. Premature _____ Full term _____	7. Legiti- mate? _____	8. Date of birth <u>12/09</u> , 19 <u>21</u> (Month, Day, Year)
--------	---	---------------------------------------	---------------------------	--

9. Full name <u>Reed</u> FATHER	18. Full maiden name <u>Walls</u> MOTHER
------------------------------------	---

10. Residence (usual place of abode) (If non-resident, give place and State) _____	19. Residence (usual place of abode) (If non-resident, give place and State) _____
---	---

11. Color or race _____	12. Age at last birthday _____ (years)	20. Color or race _____	21. Age at last birthday _____ (years)
-------------------------	--	-------------------------	--

13. Birthplace (city or place) (State or Country) _____	22. Birthplace (city or place) (State or Country) _____
--	--

OCCUPATION	14. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____	OCCUPATION	23. Trade, profession, or particular kind of work done, as housekeeper, typist, nurse, clerk, etc. _____
	15. Industry or business in which work was done, as silk mill, sawmill, bank, etc. _____		24. Industry or business in which work was done, as own home, lawyer's office, silk mill, etc. _____
	16. Date (month and year) last engaged in this work _____, 19 _____		17. Total time (years) spent in this work _____

27. What prophylactic was used to prevent Ophthalmia Neonatorum? \_\_\_\_\_

28. Number of children of this mother (At time of this birth and including this child)  
(a) Born alive and now living \_\_\_\_\_ (b) Born alive but now dead \_\_\_\_\_ (c) Stillborn \_\_\_\_\_

29. If stillborn, period of gestation _____ { months or weeks	30. Cause of stillbirth _____ { Before labor _____ During labor _____
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ m. on the date above stated.  
(Born Alive or Stillborn)

(Signed) \_\_\_\_\_, M. D.

or \_\_\_\_\_, Midwife

Address \_\_\_\_\_

Filed \_\_\_\_\_, 193 \_\_\_\_\_

When there was no attending physician or midwife, then the father, householder, etc., should make this return.

Give name added from a supplemental report \_\_\_\_\_

(Date of) \_\_\_\_\_

Registrar.

Registrar.

144-117-014-759

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-3-17

County of CanyonJAN 10 1921  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 97773

City of CaldwellRegistration District No. 3

File No. ....

No. Michigan & Walnut St.Primary Registration District No. 1005Registered No. 979

Hospital .....

FULL NAME OF CHILD Chester Daniel Judd

Sex of Child <u>Male</u>	Twin Triplet or other? <u>1</u>	and { Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>Dec. 17</u> (Month) (Day) (Year) <u>1921</u>
(To be answered only in event of plural births)				

FATHER FULL NAME <u>Charles Benedict Judd</u>		MOTHER FULL MAIDEN NAME <u>Marcella Ferguson</u>	
RESIDENCE <u>Caldwell</u>		RESIDENCE <u>Caldwell</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Bryant South Dakota</u>		BIRTHPLACE <u>Cash Valley, Idaho</u>	
OCCUPATION <u>Laborn</u>		OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth. 1 Number of children of this mother now living, including present birth. None

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 2:30 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) P. H. Young M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address .....

Filed Dec. 27, 1921

Registrar

Registrar

✓  
The following is a list of the

names of the persons who

have been named in the

minutes of the

meeting of the

Board of Directors

of the company, and the names of the persons who

have been named in the minutes of the

meeting of the

Board of Directors

of the

company, and the names of the persons who

have been named in the minutes of the

meeting of the

Board of Directors

of the

company, and the names of the persons who

have been named in the minutes of the

meeting of the

Board of Directors

of the

company, and the names of the persons who

have been named in the minutes of the

RECEIVED  
FEB 17 1922  
BUREAU OF VITAL  
STATISTICS

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE

Boise, Idaho,..... FEB 13 1922.....192...

Dear Madam:

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

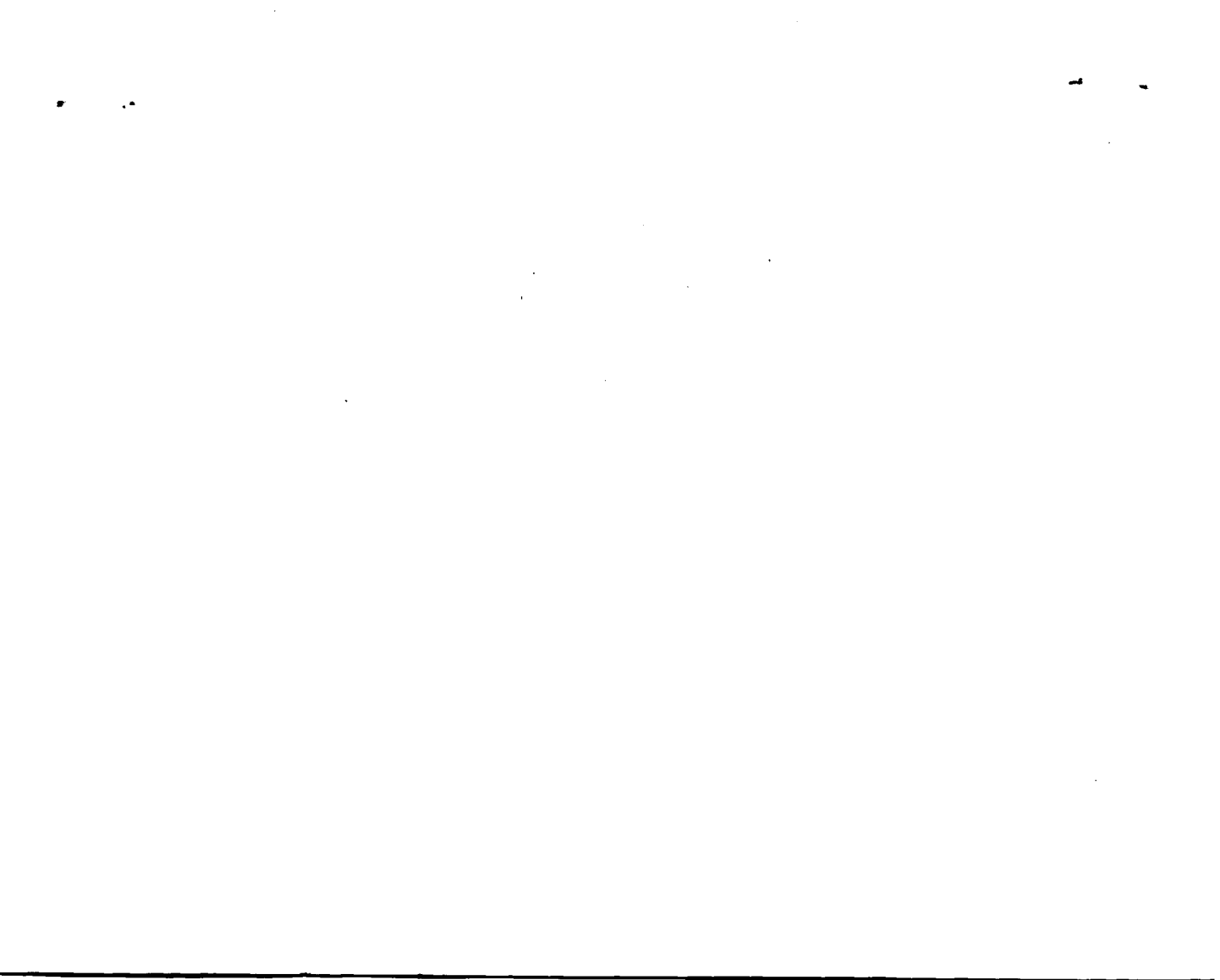
BUREAU OF VITAL STATISTICS.

Place of Birth { City ..... *Caldwell* .....  
Street ..... *Michigan Ave.* .....  
County ..... *Canyon* .....  
File Number ..... *97773* .....  
Registration Dist. No. ....  
Sex of Child ..... *Male* .....  
Date of Birth ..... *Dec 17* ..... 192*2* .....  
Father ..... *Charles Demetrios Judd* ..... Mother ..... *Marcella Ferguson* .....  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

..... *Chester Daniel Judd* .....  
Child's Name in Full

..... *Mrs & Mr Charles Judd* .....  
Signature of Father or Mother



## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 36385  
Registered No. 128

## 1. PLACE OF DEATH

County of Canyon  
City of Caldwell

Registration District No. 3  
Primary Registration District No. 2005  
(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Judd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED (Write the word.)

## 6. DATE OF BIRTH

Dec 17 1921  
(Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min. ?  
Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

Nurse

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

Chas. D. Judd

## 11. BIRTHPLACE OF FATHER

(State or Country)

South. Dak.

## 12. MAIDEN NAME OF MOTHER

Marcella Ferguson

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles D. Judd  
(Address) Caldwell Idaho

## 15.

Filed Dec. 18 - 1921 John H. Meyer  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec 17 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

Dec. 18 - 1921

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) R. G. Young M. D.

1217 1921 (Address) Caldwell

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

Parma Cem

## DATE OF BURIAL

12-18-21

## 20. UNDERTAKER

V. Beckham

## ADDRESS

Caldwell



A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

386-218-014-252  
PLACE OF BIRTHSTATE OF IDAHO  
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-0-22a-037

## CERTIFICATE OF BIRTH

S 97774

County of....Canyon.....

City of....Caldwell.....

Registration District No. ....

File No. ....

No. ....St.

Primary Registration District No. ....2005

Registered No. ....280

Hospital Caldwell Sanitarium

FULL NAME OF CHILD .....

Sex of Child	Female	Twin Triplet or other? (To be answered only in event of plural births)	and (Number in order of birth)	Legitimate?	Yes	Date of Birth	12/18/1911
						(Month)	(Day) (Year)

FULL NAME	FATHER
T. H. Thompson	
RESIDENCE	
Homedale, Idaho R. #1	
COLOR	AGE AT LAST BIRTHDAY
White	20 (Years)
BIRTHPLACE	
Washington	
OCCUPATION	
Farming	

FULL MAIDEN NAME	MOTHER
Marie Bess	
RESIDENCE	
Homedale, Idaho, R. #1	
COLOR	AGE AT LAST BIRTHDAY
White	24 (Years)
BIRTHPLACE	
Idaho	
OCCUPATION	
Housewife	

Number of child of this mother, including present birth.... Number of children of this mother now living, including present birth....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn (Born alive or stillborn), at 6:55 A.M. on the date above stated.

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature).....F. Cole.....

M. D. (Physician or midwife)

Given names added from a supplemental report.

Address.....Caldwell, Idaho.....

Filed.....Dec. 20-1921.....John H. Ineyes.....

Registrar

Registrar

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

MARGIN RESERVED FOR BINDING

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

## CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 36584

## 1. PLACE OF DEATH

County of CanyonCity of CaldwellRegistration District No. 3Primary Registration District No. 2003

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Registered No. 129

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX female4. COLOR OR RACE white

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED \_\_\_\_\_

(Write the word.)

6. DATE OF BIRTH Dec 17 1921

(Month)

(Day)

(Year)

## 7. AGE \_\_\_\_\_

Yrs. \_\_\_\_\_

Mos. \_\_\_\_\_

ds. \_\_\_\_\_

IF LESS than 1 day  
how many \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?

## 8. OCCUPATION \_\_\_\_\_

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho

(State or Country)

10. NAME OF FATHER T. H. Thompson11. BIRTHPLACE OF FATHER Washington

(State or Country)

12. MAIDEN NAME OF MOTHER Alie M. Bess13. BIRTHPLACE OF MOTHER Idaho

(State or Country)

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) V. D. Thompson(Address) Homedale Ida15. Dec 20 - 1921

Filed

1921

John D. Ingers  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 17 1921

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased Dec 17 1921 to \_\_\_\_\_that I last saw him alive on Shelton 19 \_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Shelton

(Duration) \_\_\_\_\_

Yrs. \_\_\_\_\_

mos. \_\_\_\_\_

ds. \_\_\_\_\_

Contributory  
(Secondary)

(Duration) \_\_\_\_\_

Yrs. \_\_\_\_\_

mos. \_\_\_\_\_

ds. \_\_\_\_\_

(Signed) M. Bess

M. D.

17/19 21 (Address) Caldwell Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days.

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL Canyon HillDATE OF BURIAL 12-20-192120. UNDERTAKER E. V. PeckhamADDRESS Caldwell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid ~~Housekeepers~~, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

816-218-015-288  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of Caribou

RECEIVED

FEB 1 - 1922

CERTIFICATE OF BIRTH

S 97783

City of \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

BUREAU OF  
STATISTICS

Registration District No. 82

File No. \_\_\_\_\_

Hospital \_\_\_\_\_

Primary Registration District No. 2159

Registered No. 10

FULL NAME OF CHILD

Stillborn

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <input checked="" type="checkbox"/> { and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Dec. 18, 1921</u> (Month) (Day) (Year)
----------------------------	---	-----------------------------	---

What bacteriocidal solution was used in eyes? no

Number of child of this mother, including present birth 11 Number of child of this mother now living, including present birth 8

FATHER  
FULL NAME Robert S. Hawker  
RESIDENCE Soda Springs  
COLOR white AGE AT LAST BIRTHDAY 37 (Years)  
BIRTHPLACE Utah  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Lydia Rybee  
RESIDENCE Soda Springs  
COLOR white AGE AT LAST BIRTHDAY 36 (Years)  
BIRTHPLACE Utah  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn, at 10:30 A., M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Russell Tigent  
Physician  
(Physician or midwife)

Give names added from a supplemental report.  
Quiskau, Lys, 19\_\_\_\_  
Registrar.

Address Soda Springs  
Filed Jan 31, 1922 Edwin K. Kirby  
Registrar.

BLACK ON WHITE

REAR  
T  
CHAC

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

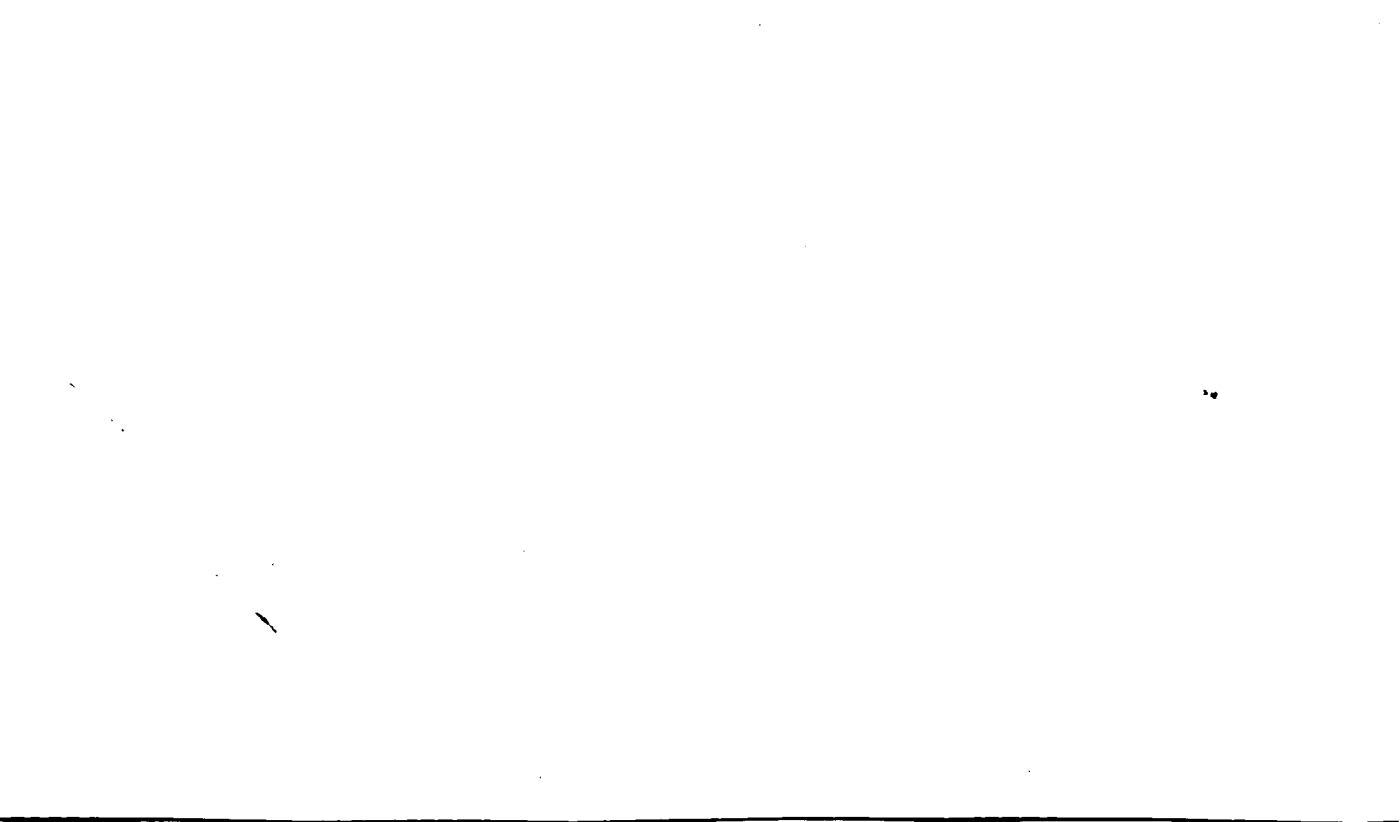
Place of Birth { City *Soda Springs, Ida.* File Number *97783*  
Street .....  
County .....  
Registration Dist. No. ....  
*Our baby was still born.*  
Sex of Child *Female* Date of Birth *Jan. 18.* 192*2.*  
Father *Robert S. Hawker* Mother *Lydia Bybee*  
Full Name Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

Child's Name in Full

*Robert S. Hawker* *Lydia B. Hawker*  
Signature of Father or Mother





N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

# RECEIVED CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH.

FEB 1 1922

Registration District No.

82

County of Caribou

BUREAU OF HEALTH

Registration District No.

2159

City of Soda Springs

STATISTICS

(No.)

St.)

File No. 36590

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still Born

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec

18

1921

(Month)

(Day)

(Year)

7. AGE

Still Born

IF LESS than 1 day,  
how many ..... hrs. or  
..... mins.?

Yrs.

Mos.

Ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Soda Springs, Idaho

10. NAME OF FATHER

Robert Hawker

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Jane Lewis

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. Russell Tizard

(Address)

Soda Springs, Idaho

15.

Filed

Jan 31, 1922

Ed W. Holman

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec

18

1921

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 18

1921

to Dec 18

1921

that I last saw him alive on Dec 18

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

Not Known

Premature Still Born

(Duration)

Yrs.

Mos.

Ds.

Contributory

None

(Secondary)

(Duration)

Yrs.

Mos.

Ds.

(Signed)

Ed W. Holman

M. D.

Dec 18 1921 (Address) Soda Springs, Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Yrs.

Mos.

Days

In the

State

Yrs.

Mos.

Days

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Soda Springs, Idaho

Dec 18, 1921

20. UNDERTAKER

ADDRESS

Ed W. Holman

Soda Springs, Idaho

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

212-212-029-396

PLACE OF BIRTH

RECEIVED  
JAN 16 1922  
VITAL

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of Zatah

City of Kendrick Ida

Registration District No. 68

File No. **S 97871**

No. \_\_\_\_\_ St.

Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

THE Nellmae Baker

Sex of Child <u>Female</u>	Twins or other? <u>Yes</u>	and	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>Nov 12</u> 19 <u>21</u> (Month) (Day) (Year)
----------------------------	----------------------------	-----	-----------------------------------	------------------------	--

FATHER  
FULL NAME Henry C Baker  
RESIDENCE Kendrick Ida  
COLOR White AGE AT LAST BIRTHDAY 28 (Years)  
BIRTHPLACE Linden Ida  
OCCUPATION Farmer

MOTHER  
FULL MAIDEN NAME Winifred Crocker  
RESIDENCE Kendrick Ida  
COLOR White AGE AT LAST BIRTHDAY 18 (Years)  
BIRTHPLACE Everett Wash  
OCCUPATION Housewife

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Full term, at 680 M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Kelly  
(Physician or midwife)

Given names added from a supplemental report.

Address Kendrick Ida  
Filed Jan 16 1922 R. F. Papp  
Registrar



363-212-038-319

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTHCounty of PayetteCity of PayetteRegistration District No. 4File No. S 97920

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. 1008 Registered No. 3

## FULL NAME OF CHILD

Sex of Child <u>Female</u>	Twin <u>Twin</u> or other <u>and</u>	Number in order of birth <u>1st</u>	Legitimate? <u>yes</u>	Date of Birth <u>Oct 12 21</u> (Month) (Day) (Year)
----------------------------	--------------------------------------	-------------------------------------	------------------------	--

FULL NAME <u>Guy Lockerman</u>	FATHER
RESIDENCE <u>Payette Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>31</u> (Years)
BIRTHPLACE <u>North Carolina</u>	
OCCUPATION <u>Postal Clerk</u>	

FULL MAIDEN NAME <u>Corra M. Caries</u>	MOTHER
RESIDENCE <u>Payette Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Virginia</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth <u>5</u>	Number of children of this mother now living, including present birth <u>4</u>
--	--

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 11:30 p. M. on the date above stated.  
(Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. C. Woodward M.D.

(Physician or midwife)

Given names added from a supplemental report.

19

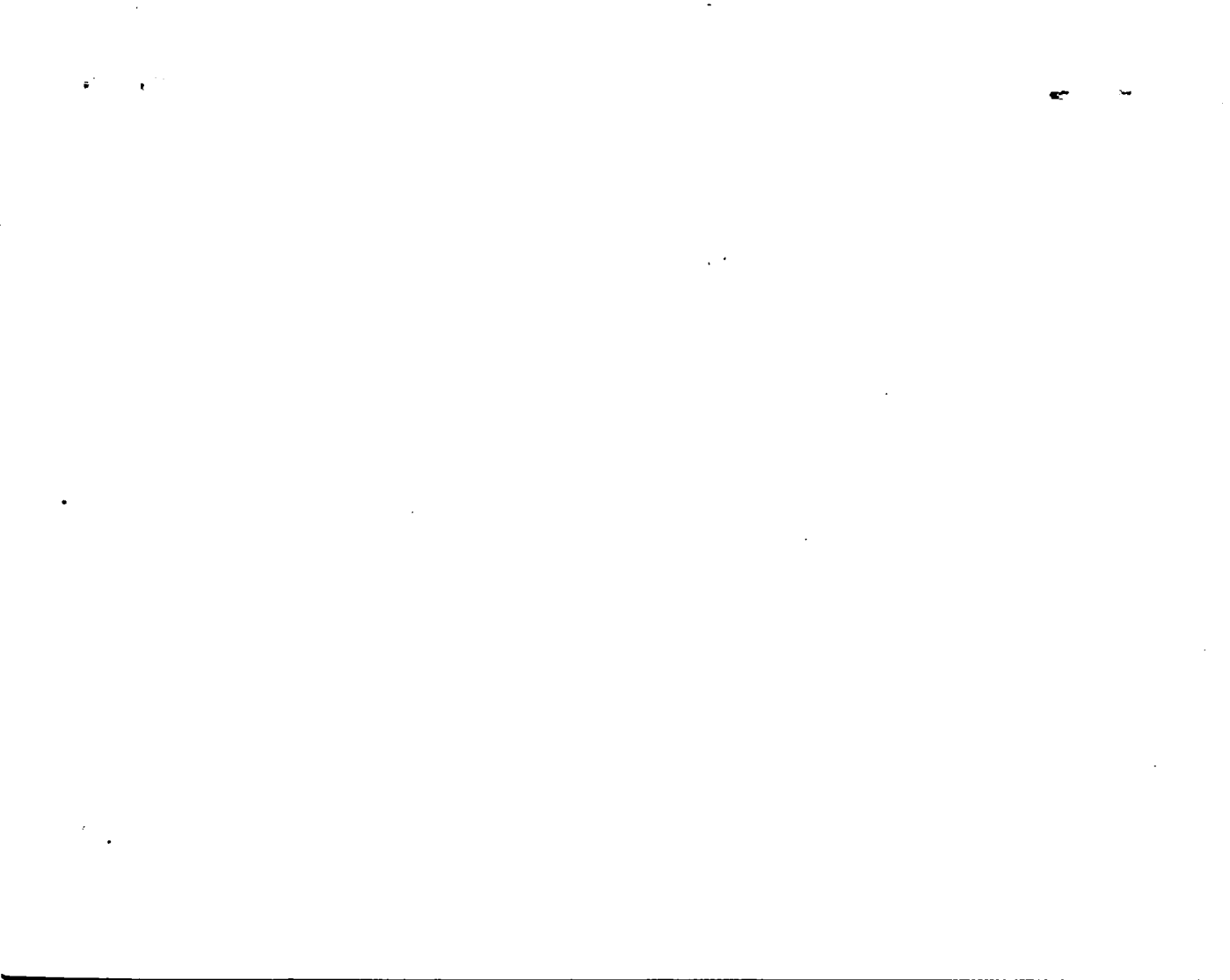
Address Payette IdahoFiled Jan 20 1922 J. C. Woodward

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics  
File No. 36185  
Registered No. 37

1. PLACE OF DEATH

County of *Payette*  
City of *Payette*

RECEIVED  
NOV 30 1921

BUREAU OF VITAL  
STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Cockrum*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH *Oct 12 1921*  
(Month) (Day) (Year)

7. AGE *Stillborn* IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION  
(a) Trade, profession or particular kind of work. *Infant*  
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE *P. Idaho*  
(State or Country)

10. NAME OF FATHER *G. J. Cockrum*

11. BIRTHPLACE OF FATHER *N. Carolina*  
(State or Country)

12. MAIDEN NAME OF MOTHER *Cora Carico*

13. BIRTHPLACE OF MOTHER *Virginia*  
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Guy E. Cockrum*  
(Address) *Payette Ida*

15. Filed *Oct 14 1921* *J. E. Woodward*  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct 12 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19... to 19... that I last saw him alive on 19... and that death occurred on the date stated above, at 11:24 P.M. The CAUSE OF DEATH was as follows: *Stillborn*

(Duration) Yrs. mos. ds. Contributory (Secondary)

(Duration) yrs. mos. ds. (Signed) *W. H. Woodward* M. D. 10/13/21 (Address) *Payette, Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)  
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Payette Ida* DATE OF BURIAL *10-13-1921*

20. UNDERTAKER *J. H. Hagan* ADDRESS *Payette Ida*



A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

695-221-038-751

Form V. S. No. 11-C-25m-7-21-19

## PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

County of

Payette

JAN 20 1922

## CERTIFICATE OF BIRTH

S

City of

Payette

Registration District No.

4

File No.

97933

No.

St.

Primary Registration District No.

1008

Registered No.

16

## FULL NAME OF CHILD

Sex of Child

Female

Twin  
Triplet  
or other?

{ and }

Number  
in order  
of birth

(To be answered only in event of plural births)

Legitimate?

Yes

Date of Birth

Dec 21 1921  
(Month) (Day) (Year)

FULL NAME

FATHER

J. E. White

FULL MAIDEN NAME

MOTHER

May E. Pearson

RESIDENCE

Payette Idaho

RESIDENCE

Payette Idaho

COLOR

White

AGE AT LAST BIRTHDAY

33  
(Years)

COLOR

White

AGE AT LAST BIRTHDAY

26  
(Years)

BIRTHPLACE

Idaho

BIRTHPLACE

Idaho

OCCUPATION

Farmer

OCCUPATION

Housewife

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn, at 10 A. M. on the date above stated.  
(Born alive or stillborn)

(Signature)

J. E. Woodward M.D.

(Physician or midwife)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given names added from a supplemental report.

19

Address

Payette Idaho

Filed

Jan 20 1922 J. E. Woodward

Registrar

Registrar

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

11

199-105-042-369  
PLACE OF BIRTHSTATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

County of Twin Falls RECEIVED  
JAN 21 1922  
City of \_\_\_\_\_  
No. \_\_\_\_\_ BUREAU OF VITAL  
STATISTICSRegistration District No. 37File No. 98012Hospital \_\_\_\_\_ Primary Registration District No. 2085 Registered No. \_\_\_\_\_

FULL NAME OF CHILD

Arrington

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ and _____ Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Dec 5</u> 192 <u>1</u> (Month) (Day) (Year)
--------------------------	---	------------------------	---

(To be answered only in event of plural births)

What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 3

FULL NAME <u>N. W. Arrington</u>	FATHER	FULL MAIDEN NAME <u>Edna G. Corn</u>	MOTHER
RESIDENCE <u>Twin Falls</u>		RESIDENCE <u>Twin Falls</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>32</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)
BIRTHPLACE <u>Tenn</u>		BIRTHPLACE <u>Ind</u>	
OCCUPATION <u>farmer</u>		OCCUPATION <u>Housewife</u>	

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at 69 M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Ann Louche  
Physician  
(Physician or midwife)

Give names added from a supplemental report.

Address Twin Falls, IdahoFiled Jan 2 - 1922 John F. Connelley  
Registrar.

Registrar.

1990

10

1990

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM-V. S. No. 5-A-25 M. 1-19.

RECEIVED

DEC 18 1921

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Winnefall BUREAU OF VITAL STATISTICS  
 City of Idaho (No. 37)  
 State of Idaho  
 Board of Health  
 Bureau of Vital Statistics  
 File No. 36275  
 Registered No. 36275

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Harrington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single (Write the word.)

6. DATE OF BIRTH

Dec 5 1921  
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
 how many hrs.  
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

N. W. Harrington

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Edna Carr

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N. W. Harrington

(Address)

Winnefall

15.

Filed Dec 5 1921

John T. Loughlin  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 5 1921  
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1921 to Dec 5 1921

that I last saw him alive on Dec 5 1921

and that death occurred on the date stated above, at Idaho M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. Louchet M. D.

19 (Address) Winnefall, Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Winnefall

Dec 5 1921

20. UNDERTAKER

ADDRESS

Broseman

Winnefall

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

✓ 89  
1  
**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

354-122-042 F 799  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

County of *Twin Falls*

City of *Jerome*

No. *1085* St. *1085*

Hospital *1085*

RECEIVED

JAN 21 1922

BUREAU District No. *37*

STATIST

Primary Registration District No. *1085*

File No.

S

98016

Registered No.

FULL NAME OF CHILD

(Certificate of no value without full name of child.)

Sex of Child <i>M</i>	Twin Twins or other? (To be answered only in event of plural births)	and { Number in order of birth <i>1/1</i>	Legiti- mate? <i>yes</i>	Date of birth <i>12 22</i> 192 <i>1</i> (Month) (Day) (Year)
-----------------------	---	---	-----------------------------	--

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth *4* Number of children of this mother now living, including present birth *3*

FATHER  
FULL NAME *Alvin T. Thompson*

RESIDENCE *Jerome*

COLOR *M* AGE AT LAST BIRTHDAY *39* (Years)

BIRTHPLACE *Idaho*

OCCUPATION *Farmer*

MOTHER  
FULL MAIDEN NAME *Clara Fritz*

RESIDENCE *Jerome*

COLOR *M* AGE AT LAST BIRTHDAY *36* (Years)

BIRTHPLACE *Idaho*

OCCUPATION *Housewife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was *12 22 21* at *11-30 A. M.*  
on the date above stated. (Born *alive* or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) *T. M. Mearns*

(Physician or midwife)

Give names added from a supplemental report.

Address *Jerome*

Filed *Jan 7 1922*

Registrar.

Registrar.



THIS IS A LEGAL RECORD  
 THE STATE OF CALIFORNIA  
 COUNTY OF ...  
 CITY OF ...  
 I, the undersigned, being a duly qualified and sworn official of the County of ... and City of ... do hereby certify that the foregoing is a true and correct copy of the original record on file in my office.

DEPARTMENT OF PUBLIC WELFARE  
 BUREAU OF VITAL STATISTICS  
 COUNTY OF ...  
 CITY OF ...

**CERTIFICATE OF BIRTH**

County of \_\_\_\_\_  
 City of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

Full name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

What protection was used in case of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

What protection was used in case of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

What protection was used in case of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

What protection was used in case of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

What protection was used in case of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

What protection was used in case of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

What protection was used in case of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

What protection was used in case of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

What protection was used in case of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

What protection was used in case of \_\_\_\_\_  
 Name of child \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Place of birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Color \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Birthplace \_\_\_\_\_  
 Age at last birthday \_\_\_\_\_

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Twain Falls*

Registration District No. *37*

*37019*

Primary Registration District No. *1085*

File No. ....

City of .....

(No. .... St.) .....

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Infant Cedarburg*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED

*M* *white* *Infant*  
(Write the word.)

6. DATE OF BIRTH

*Dec 22* *1921*  
(Month) (Day) (Year)

7. AGE

*0* Yrs. *0* Mos. *0* ds.

IF LESS than 1 day  
how many..... hrs.  
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

*Infant*

9. BIRTHPLACE

(State or Country)

*Idaho*

10. NAME OF FATHER

*Albert Cedarburg*

11. BIRTHPLACE OF FATHER

(State or Country)

*Nebr*

12. MAIDEN NAME OF MOTHER

*Clara Juretz*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Nebr*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Albert Cedarburg*  
*Twain Falls Ida*

15.

Filed *Jan 29* *1922* *John A. ...*  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Dec 22* *1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to ..... 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date stated above, at *1* *PM*.

The CAUSE OF DEATH\* was as follows:

*blue ...*

..... (Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

..... (Duration) ..... yrs. .... mos. .... ds.

(Signed) *Swanson* ..... M. D.

*129* *1922* (Address) *Twain Falls*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Twain Falls* *12 29 1921*

20. UNDERTAKER

ADDRESS

*Twain Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

764-110-003-519  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

**S**  
**98113**

County of Bannock

City of ocatello

No. 7th Ave. St.

Hospital St. Anthony's

RECEIVED CERTIFICATE OF BIRTH

Registration District No. 28

File No. 76

BUREAU OF VITAL STATISTICS

Primary Registration District No. 2141

Registered No. 4159

FULL NAME OF CHILD

No Name

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin <input checked="" type="checkbox"/> Triplet <input checked="" type="checkbox"/> or other? <input checked="" type="checkbox"/> and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Dec 10 1921</u> (Month) (Day) (Year)
--------------------------	---	------------------------	--

What bacteriocidal solution was used in eyes? agnos 17%

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 3

FATHER  
FULL NAME Jay N. Goddard

RESIDENCE Minadoka

COLOR White AGE AT LAST BIRTHDAY 33 (Years)

BIRTHPLACE Nebraska

OCCUPATION Station Agent

MOTHER  
FULL MAIDEN NAME Anna Earnest

RESIDENCE Minadoka

COLOR White AGE AT LAST BIRTHDAY 28 (Years)

BIRTHPLACE Wb

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:00 P. M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) H. A. Wright  
Physician

(Physician or midwife)

Give names added from a supplemental report.

Address Home 2141

Filed 2/1 1922 Registrar.

Registrar.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR

NAME COMPLETED BY FURNISHING THE NAME OF THE CHILD.  
CERTIFICATE OF THE BUREAU OF  
OF

OFFICE

The name of your baby was not filled in on the birth certificate sent to you. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City .....  
                  { Street .....  
                  { County .....

File Number ..... 98113

Registration Dist. No. ....

Sex of Child..... Male ..... Date of Birth ..... 192....

Father ..... Full Name      Mother ..... Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

.....  
Child's Name in Full

.....  
Signature of Father or Mother

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE FILED FOR EACH CHILD AND THE SAME COMPLETED WITH THE NAME OF CHILD.

Birth registration is part of every child's birthright.  
It establishes legally the date of the child's birth, parentage  
and legitimacy.

It enables the Public Health Nurse to make sure the child has  
been protected from danger of blindness and other infections at birth.

- - - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time.

## CERTIFICATE OF DEATH

36342

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of *Bannock*  
City of *Pocatello*Registration District No. *28*Primary Registration District No. *2161*(No. *St. Anthony Hospital*)File No. *46*Registered No. *3723*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

*Jay, Jr. Goddard*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Male White*

(Write the word.)

## 6. DATE OF BIRTH

*Dec 19 1921*  
(Month) (Day) (Year)

## 7. AGE

*Still Born*  
Yrs. Mos. ds.IF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work  
(b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

*Idaho*

## 10. NAME OF FATHER

*Jay Goddard*

## 11. BIRTHPLACE OF FATHER

(State or Country)

*Idaho*

## 12. MAIDEN NAME OF MOTHER

*Anna Ernest*

## 13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Jay Goddard*  
*Wendover Idaho*

## 15.

Filed

*12/20 1921*

Local Registrar

## 16. DATE OF DEATH

*December 19th*  
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Dec 19th 1921* to *Dec 19th 1921*

that I last saw him..... alive on..... never..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

*Still-born.*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

*W. A. Wright* M. D.  
*12/20 1921* (Address) *Pocatello, Ida*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Idaho Falls Ida* *Dec 21 1921*

## 20. UNDERTAKER

## ADDRESS

*Chumacke & Sons Pocatello*



A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

866-116-020-249

PLACE OF BIRTH

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of ElmoreCity of Mt HomeRegistration District No. 34File No. **S 98450**

No. \_\_\_\_\_ St.

Primary Registration District No. 2020Registered No. 82

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Hopkins

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti mate? <u>Yes</u>	Date of Birth <u>12-16-</u> <u>1921</u>
				(Month) (Day) (Year)

FATHER  
FULL NAME Elmer Hopkins  
RESIDENCE Mt Home Ida  
COLOR White AGE AT LAST BIRTHDAY 30  
(Years)  
BIRTHPLACE Okl  
OCCUPATION Laborer

MOTHER  
FULL MAIDEN NAME Bessie Smith  
RESIDENCE Mt Home Ida  
COLOR White AGE AT LAST BIRTHDAY 29  
(Years)  
BIRTHPLACE Kansas  
OCCUPATION \_\_\_\_\_

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 3

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was Stillborn, at 2, A M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) \_\_\_\_\_

(Physician or midwife)

Given names added from a supplemental report.

Address \_\_\_\_\_

Filed 1-1- 1922

Registrar

Registrar

File No.

Registered No.

Date of birth (Month) (Day) (Year)

MOTHER

AGE AT LAST BIRTHDAY

CERTIFICATE OF ATTENDING PHYSICIAN OF MIDWIFE.

(Signature)

(Signature of Midwife)

I hereby certify that the child is the child of the mother and father named above and was born at the place and date stated above.

44-11102

FORM V. S. No. 5-25 M. 1-19.

## ✓ CERTIFICATE OF DEATH

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Elmore  
City of Mtn HomeRegistration District No. 34Primary Registration District No. 2020

(No. .... St.)

File No. 36848Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Infant son of Elmer Hopkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single  
(Write the word.)

## 6. DATE OF BIRTH

December 16 1921  
(Month) (Day) (Year)

## 7. AGE

Yrs. Mos. ds.

IF LESS than 1 day  
how many ..... hrs.  
or ..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country)

Mtn Home Ida

## 10. NAME OF FATHER

Elmer Hopkins

## 11. BIRTHPLACE OF FATHER

(State or Country)

Oklahoma

## 12. MAIDEN NAME OF MOTHER

Bessie Smith

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Mtn Home Ida.

## 15.

Filed 1-1- 1922J. E. Evans  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

12 — 16 — 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

12-16-1921, to 12-16-1921,  
that I last saw him alive on 19,  
and that death occurred on the date stated above, at M.  
The CAUSE OF DEATH\* was as follows:Stillborn

(Duration) ..... Yrs. .... mos. .... ds.

Contributory  
(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed)

J. E. Evans M. D.1-1-1922 (Address) Mtn Home Ida

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. .... mos. .... days. In the State ..... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

Mtn Home Ida

## DATE OF BURIAL

1-17-1922

## 20. UNDERTAKER

A. H. Conover

## ADDRESS

Mtn Home Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

759-127-021-318

## PLACE OF BIRTH

County of... *Franklin*City of... *Clifton*No. .... *St.*

Hospital .....

FULL NAME OF CHILD .....

## RECEIVED BUREAU OF VITAL STATISTICS

FEB 21 1922

## CERTIFICATE OF BIRTH

BUREAU OF VITAL

Registration District No. .... *27*File No. .... *98458*Primary Registration District No. .... *2119*Registered No. .... *18*

Premature Perkins

Sex of Child <i>male</i>	Twin Triplet or other? <i></i>	and { Number in order of birth <i></i>	Legitimate? <i>yes</i>	Date of Birth <i>Dec 27 1921</i>
(To be answered only in event of plural births)				(Month) (Day) (Year)

FULL NAME <i>Leonard M Perkins</i>	FATHER
RESIDENCE <i>Clifton, Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>39</i> (Years)
BIRTHPLACE <i>Dayton Idaho</i>	
OCCUPATION <i>Farmer</i>	

FULL MAIDEN NAME <i>Laney Pearl Taylor</i>	MOTHER
RESIDENCE <i>Clifton Idaho</i>	
COLOR <i>White</i>	AGE AT LAST BIRTHDAY <i>25</i> (Years)
BIRTHPLACE <i>Clifton Idaho</i>	
OCCUPATION <i>Housewife</i>	

Number of child of this mother, including present birth... *1* ..... Number of children of this mother now living, including present birth... *1* .....

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was... *Stillborn* ... at... *5 PM* ... on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. (Signature) *Esther E. Lloyd Davis*

Given names added from a supplemental report.

Address... *Clifton Idaho* ... Filed... *2-14* ... *22* ... *Mrs. Ida Taylor* ... Registrar

WRITE PLAINLY WITH UNFADING INK- THIS IS A PERMANENT RECORD

N. B. In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

SEVERAL REASONS WHY A CERTIFICATE

RECEIVED

RECEIVED

Dear Madam:

RECEIVED

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City .....  
                  { Street .....  
                  { County .....

File Number ..... 98458

Registration Dist. No. ....

Sex of Child..... Male .....

Date of Birth ..... 192....

Father .....  
                  Full Name

Mother .....  
                  Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

.....  
Child's Name in Full

.....  
Signature of Father or Mother

OVER

*Premature*



Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

----- IT SHOWS AT LATER PERIODS OF LIFE: -----

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

533.122-026-313  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S

98610

County of JeffersonCity of RigbyRegistration District No. 98

File No.

No. 31Primary Registration District No. 2176Registered No. 311

Hospital \_\_\_\_\_

FULL NAME OF CHILD Baby EllisSex of Child mTwin  
Triplet  
or other?  
(To be answered only in event of plural births)

and

Number  
in order  
of birthLegiti-  
mate? yesDate of  
Birth12 22 21  
(Month) (Day) (Year)FULL  
NAME

FATHER

John EllisFULL  
MAIDEN  
NAME

MOTHER

Laura Call

RESIDENCE

Rigby R.D.

RESIDENCE

same

COLOR

wAGE AT LAST  
BIRTHDAY

(Years)

COLOR

wAGE AT LAST  
BIRTHDAY

(Years)

BIRTHPLACE

Utah

BIRTHPLACE

Utah

OCCUPATION

Farmer

OCCUPATION

at home

Number of child of this mother, including present birth

Number of children of this mother now living, including present birth

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was stillborn at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or  
midwife then the father, householder, etc.,  
should make this return. A stillborn child is  
one that neither breathes nor shows other evi-  
dence of life after birth.

(Signature) O. J. Call

(Physician or midwife)

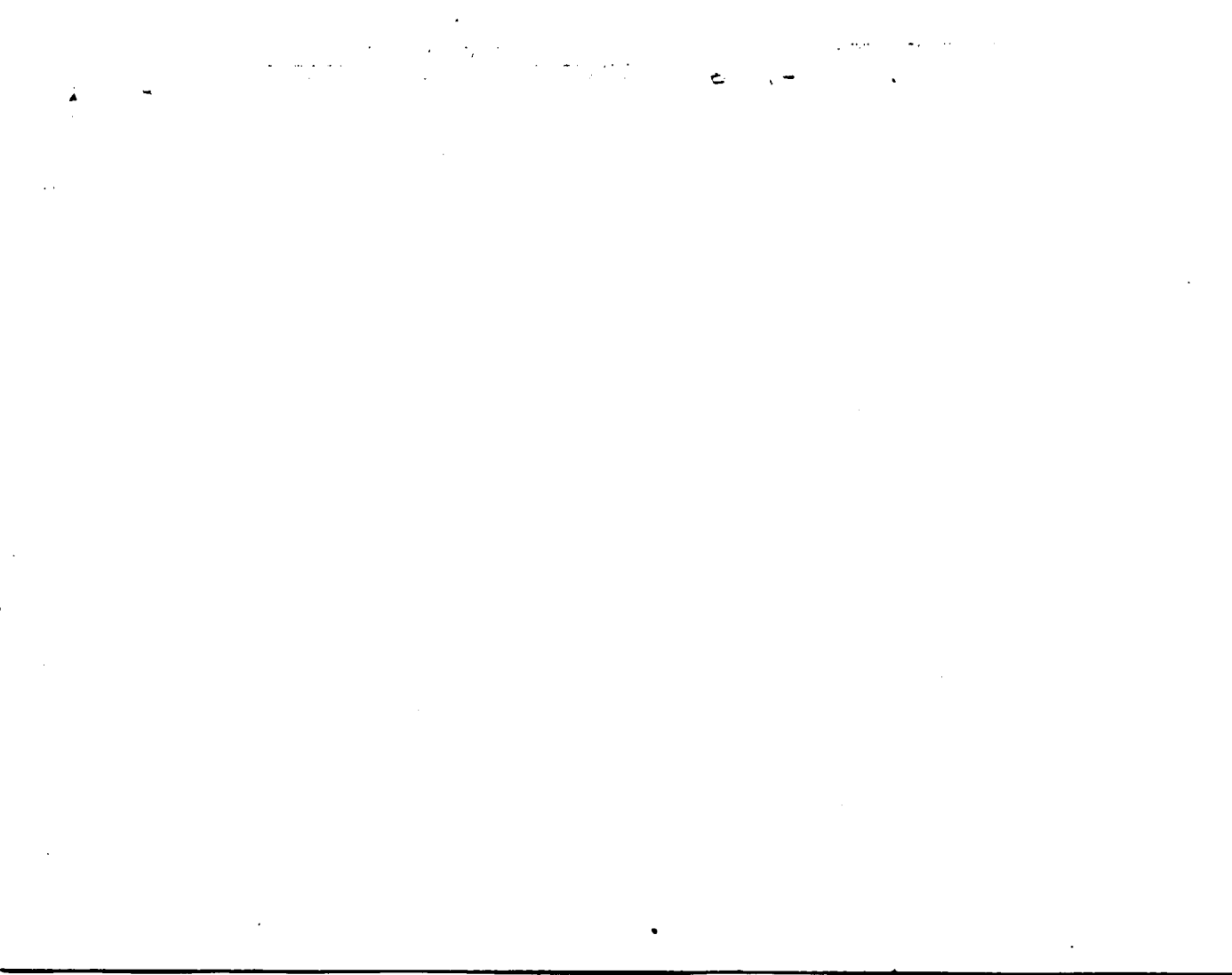
Given names added from a supplemental report.

19

Address RigbyFiled 12/20 1921

Registrar.

Registrar.



## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County of Jefferson Registration District No. 98  
 City of Highway Primary Registration District No. 2176  
 F.R. No. \_\_\_\_\_ St.) \_\_\_\_\_

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Baby Ellie

State of Idaho  
 BOARD OF HEALTH  
 Bureau of Vital Statistics

File No. 36905  
 Registered No. \_\_\_\_\_

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant  
 (Write the word.)

## 6. DATE OF BIRTH

Dec 22 1921  
 (Month) (Day) (Year)

## 7. AGE

IF LESS than 1 day  
 how many \_\_\_\_\_ hrs.  
 or \_\_\_\_\_ min. ?  
 Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ ds.

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.  
 (b) General nature of industry, business or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country) Idaho

## 10. NAME OF FATHER

John Ellis

## 11. BIRTHPLACE OF FATHER

(State or Country) Utah

## 12. MAIDEN NAME OF MOTHER

Laura Call

## 13. BIRTHPLACE OF MOTHER

(State or Country) Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Ellis

(Address) Coronzo #1 Idaho

## 15.

Filled 12/22 1921 Ray H. Fisher  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

12 - 22 1921  
 (Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_,  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_,  
 and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Still born

\_\_\_\_\_ (Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
 (Secondary)

\_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Dr. G. F. Call

12/22/21 (Address) Highway

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Annies Ida 12/22/21

## 20. UNDERTAKER

## ADDRESS

W. L. Young Highway

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1140

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

957-23044714

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

County of WashingtonCity of Weiser

No. \_\_\_\_\_ St. \_\_\_\_\_

Registration District No. \_\_\_\_\_

86

File No. \_\_\_\_\_

98897

Hospital \_\_\_\_\_

Primary Registration District No. 1010Registered No. 12FULL NAME OF CHILD Vernon Ingebretsen

(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>#</u> } and { Number in order of birth <u>7</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>12 23 1921</u> (Month) (Day) (Year)
--------------------------	---	-----------------------------	---

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes? None

Number of child of this mother, including present birth \_\_\_\_\_ Number of child of this mother now living, including present birth \_\_\_\_\_

FULL NAME FATHER  
R. IngebretsenFULL MAIDEN NAME MOTHER  
Matilda PaulsonRESIDENCE Weiser, IdahoRESIDENCE Weiser, IdahoCOLOR White AGE AT LAST BIRTHDAY 49  
(Years)COLOR White AGE AT LAST BIRTHDAY 45  
(Years)BIRTHPLACE NorwayBIRTHPLACE UtahOCCUPATION Section Foreman.OCCUPATION House-wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

Still-born8.15 aI hereby certify that I attended the birth of this child, who was \_\_\_\_\_ at \_\_\_\_\_ M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C..B. Shirley, M.D.

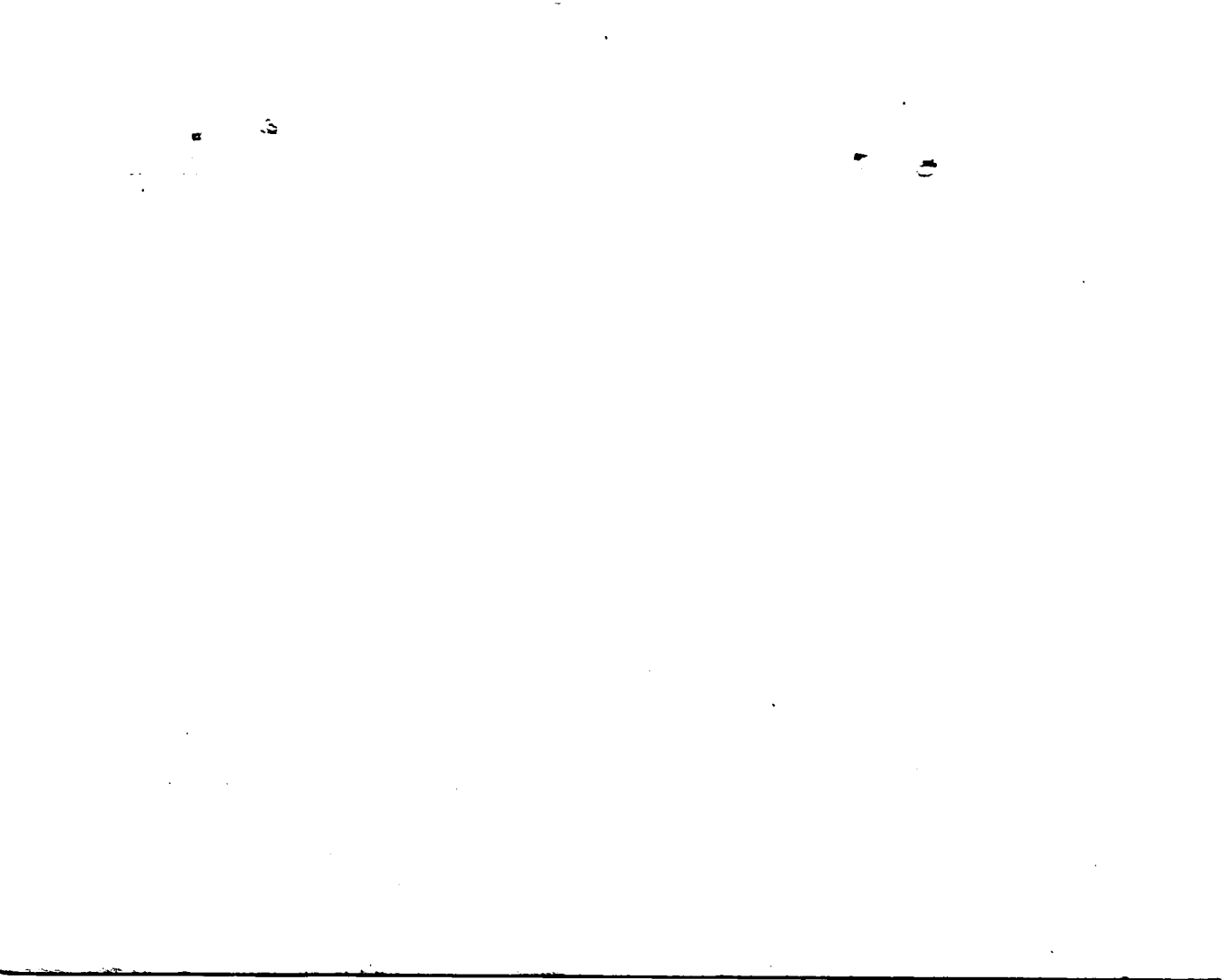
(Physician or midwife)

Give names added from a supplemental report.

Address Weiser, IdahoFiled 218 1922

Registrar.

Registrar.



FORM V. S. No. 5-25 M. 1-19.

## CERTIFICATE OF DEATH

37044

Shirley

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

## 1. PLACE OF DEATH

County of Washington  
City of WeiserRegistration District No. 86  
Primary Registration District No. 1010  
(No.        St.)File No.       Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Vernon Ingelbretsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single  
(Write the word.)

## 6. DATE OF BIRTH

Dec 23 1921  
(Month) (Day) (Year)

## 7. AGE

stillbornIF LESS than 1 day  
how many..... hrs.  
or..... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

## 9. BIRTHPLACE

(State or Country)

Idaho

## 10. NAME OF FATHER

R. Ingelbretsen

## 11. BIRTHPLACE OF FATHER

(State or Country)

Norway

## 12. MAIDEN NAME OF MOTHER

Mauda Paulsen

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. Ingelbretsen  
(Address) Weiser Idaho

## 15.

Filed 2/13 1922W. R. Hamilton  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

Dec 23 1921  
(Month) (Day) (Year)

## 17. I HEREBY CERTIFY, That I attended deceased from

19....., to 19.....that I last saw him..... alive on..... 19.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH\* was as follows:

Stillborn

(Duration)..... Yrs..... mos..... ds.

Contributory  
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)

W. R. Hamilton M. D.12/24/1921 (Address) Weiser Idaho

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

## 19. PLACE OF BURIAL OR REMOVAL

Stillcrest Cemetery

## DATE OF BURIAL

1924 1021

## 20. UNDERTAKER

Northman McLean

## ADDRESS

Weiser Idaho



A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death); 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

952-125-601-653  
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

S 98985

County of Ada.

City of

Registration District No. 124

File No. 4

No. St.

Primary Registration District No. 2202

Registered No. 121

Hospital

FULL NAME OF CHILD

Inselman. (Pre)

Sex of Child

Male.

Twin  
Triplet  
or other?  
(To be answered only in event of plural births)

and

Number  
in order  
of birthLegiti-  
mate?

Yes.

Date of Birth

12-25

1921

(Month)

(Day)

(Year)

FULL NAME

FATHER

Wayne Inselman.

RESIDENCE

Kuna.

COLOR

White-

AGE AT LAST  
BIRTHDAY

31

(Years)

BIRTHPLACE

Mich.

OCCUPATION

Farmer.

FULL  
MAIDEN  
NAME

MOTHER

Marian Wells.

RESIDENCE

Kuna.

COLOR

White.

AGE AT LAST  
BIRTHDAY

30

(Years)

BIRTHPLACE

Kansas.

OCCUPATION

House Wife.

Number of child of this mother, including present birth 3rd Number of children of this mother now living, including present birth 2.

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was on the date above stated.

Stillborn-premature

(Born alive or stillborn)

9.15, P.M.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

F. J. Coleman

Physician

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Kuna, Idaho.

Filed

2-27, 1922

Registrar.

Registrar.

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

98882

PLACE OF BIRTH

County of \_\_\_\_\_

City of \_\_\_\_\_

No. \_\_\_\_\_

Residence \_\_\_\_\_

FULL NAME OF CHILD

Sex of \_\_\_\_\_

Child \_\_\_\_\_

FULL NAME

FATHER

FULL NAME

MOTHER

RESIDENCE

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

COLOR

AGE AT LAST BIRTHDAY

BIRTHPLACE

BIRTHPLACE

OCCUPATION

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was \_\_\_\_\_ on the date above stated.

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A midwife could be one that neither priest nor nurse, other witness of the birth.

Given names added from a supplemental report

Address \_\_\_\_\_

Birth \_\_\_\_\_

THIS IS A PRELIMINARY REPORT OF BIRTH. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE FILED IN THE BUREAU OF VITAL STATISTICS. IT IS TO BE KEPT FOR FIVE YEARS. IT IS TO BE DESTROYED AFTER FIVE YEARS.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-12

## CERTIFICATE OF DEATH.

## 1. PLACE OF DEATH.

County of Ada  
City of \_\_\_\_\_

Registration District No. 124  
Primary Registration District No. 2202  
(No. \_\_\_\_\_ St.)

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

Juselman

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. **37104**Registered No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

## 6. DATE OF BIRTH.

12  
(Month)25  
(Day)1921  
(Year)

## 7. AGE

Premature and still born

IF LESS than 1 day  
how many... hrs. or  
... min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work...  
(b) General nature of industry, business, or establishment in which employed (or employer)

## 9. BIRTHPLACE

(State or Country)

## 10. NAME OF FATHER

Wayne Juselman

## 11. BIRTHPLACE OF FATHER

(State or Country)

Mich

## 12. MAIDEN NAME OF MOTHER

Marian Wells

## 13. BIRTHPLACE OF MOTHER

(State or Country)

Kans

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

## (Informant)

Wayne Juselman

(Address)

Kuma Idaho

## 15.

Filed

2-27-1922W. B. Stuenkel  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

## 16. DATE OF DEATH

12  
(Month)25  
(Day)1921  
(Year)

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 191\_\_\_\_, to \_\_\_\_\_ 191\_\_\_\_,

that I last saw him alive on \_\_\_\_\_ 191\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Premature and still born

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

W. B. Stuenkel M. D.(Address) Kuma Idaho

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. .... mos. .... days In the State... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Kuma Idaho12-25-1922

## 20. UNDERTAKER

## ADDRESS

ParentsKuma

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

243-112-022 698  
PLACE OF BIRTH

STATE OF IDAHO  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF VITAL STATISTICS

S

RECEIVED  
JUN 22 1922

CERTIFICATE OF BIRTH

County of Jerome  
City of Jerome  
No. 1017 St. 1017 Registration District No. 23 File No. 102515  
Hospital Home Primary Registration District No. 2017 Registered No. 1017

FULL NAME OF CHILD Michel James Sullivan  
(Certificate of no value without full name of child.)

Sex of Child <u>M.</u>	Twin Triplet or other? <u>Yes</u> and {Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>May 12, 1921</u> (Month) (Day) (Year)
------------------------	--	------------------------	---

What bactericidal solution was used in eyes? .....

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

FATHER  
FULL NAME Frank L. Sullivan  
RESIDENCE Jerome Idaho  
COLOR White AGE AT LAST BIRTHDAY 24 (Years)  
BIRTHPLACE Nebraska  
OCCUPATION Pharmacist

MOTHER  
FULL MAIDEN NAME Lucene M. Fryer  
RESIDENCE Jerome Idaho  
COLOR White AGE AT LAST BIRTHDAY 26 (Years)  
BIRTHPLACE Idaho  
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Sullivan, at 3:30 P.M. on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. T. Keller

Midw.  
(Physician or midwife)

Give names added from a supplemental report.  
....., 192.....  
.....  
Registrar.

Address Jerome, Idaho  
Filed June 20 1922 E. D. Piper M.D.  
Registrar.

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of child stated.

SEVERAL REASONS WHY A CERTIFICATE OF BIRTH SHOULD  
BE COMPLETED WITH THE

The name of your baby was not filled in on the birth certificate sent to this office. It is of vital importance to have the full name included in the record. Kindly fill in the information requested in the blank below and return this sheet, at your earliest convenience, in the enclosed self-addressed envelope.

BUREAU OF VITAL STATISTICS.

Place of Birth { City ..... **Jerome Idaho** .....  
Street .....  
County ... **Jerome** .....

File Number ..... **102615** .....

Registration Dist. No. ....

Sex of Child..... **Male** .....

Date of Birth ... **May 12, 1921** ..... 192....

Father .. **Frank L. Sullivan** .....  
Full Name

Mother .. **Irene M. Fryer** .....  
Full Maiden Name

I HEREBY CERTIFY that the child described herein has been named:

..... **Michel James Sullivan** .....  
Child's Name in Full

*F. L. Sullivan*

Signature of Father or Mother



Birth registration is part of every child's birthright.

It establishes legally the date of the child's birth, parentage and legitimacy.

It enables the Public Health Nurse to make sure the child has been protected from danger of blindness and other infections at birth.

- - - - IT SHOWS AT LATER PERIODS OF LIFE: - - - -

1. The correct age for purposes of school attendance.
2. Employment.
3. Protection under the law.
4. Military and jury duty.
5. Right to travel unmolested in foreign lands.
6. Right to vote.
7. Right to receive pensions and inherit property.
8. Furnishes acceptable evidence of genealogy.
9. Right to get married.
10. Just at this time while many of the Ex-Service men are compelled to furnish certified copies of certificates of birth, it is important that the certificates be filed with the BUREAU OF VITAL STATISTICS and the same completed by furnishing the name of the child.

PLEASE ASSIST BY FURNISHING THE NAME OF YOUR CHILD.

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

## CERTIFICATE OF DEATH.

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

PLACE OF DEATH

RECEIVED

In District No. 23

County of Jerome

MAY 21 1921

Registration District No. 1017-2017

City of Jerome

BUREAU OF VITAL  
STATISTICS

St.)

File No. 34250

Registered No.

If death occurs away from  
usual residence, give facts  
called for under special  
information.

2. FULL NAME *Thomas Sullivan*

If death occurred in a hos-  
pital, institution or camp,  
give its NAME instead of  
street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-  
OWED OR DIVORCED. *Single*  
(Write the word.)

6. DATE OF BIRTH.

*May 12 1921*  
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day  
how many *16* hrs. or  
*\* min.*

8. OCCUPATION

(a) Trade, profession or  
particular kind of work.  
(b) General nature of in-  
dustry, business, or estab-  
lishment in which employ-  
ed (or employer).

9. BIRTHPLACE

(State or Country)

*Jerome Ida*

10. NAME OF FATHER

*Frank L Sullivan*

11. BIRTHPLACE OF FATHER

(State or Country)

*Not*

12. MAIDEN NAME OF MOTHER

*Irma M Dwyer*

13. BIRTHPLACE OF MOTHER

(State or Country)

*Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed *5/13*

1921

*E. D. Piper*  
Local Registrar

16. DATE OF DEATH

*May 12 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from  
*May 12 1921* to *May 12 1921*  
that I last saw h. alive on *1921*

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH\* was as follows:

*Still Born Infant*

(Duration) Yrs. mos. ds.

Contributory  
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *Chas P. Keller* M. D.  
*5/12 1921* (Address) *Jerome Ida*

\*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)  
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,  
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted  
if not at place of death?

Former or  
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*one cemetery**5-13-21*

20. UNDERTAKER

ADDRESS

*J. H. Harrison**Jerome*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH.**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

*spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

133-231-014-384  
County of Canyon  
City of Caldwell  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Hospital \_\_\_\_\_  
Primary Registration District No. 2005  
Registered No. 233

RECEIVED  
DEC 30 1922  
BUREAU OF VITAL STATISTICS  
Registration District No. 3  
File No. S107565

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

FULL NAME OF CHILD Elizabeth Altig

Sex of Child <u>Female</u>	Twin, Triplet or other? <u>no</u>	and	Number in order of birth <u>First</u>	Legitimate? <u>yes</u>	Date of Birth <u>21</u> <u>1921</u> (Month) (Day) (Year)
----------------------------	-----------------------------------	-----	---------------------------------------	------------------------	---

FATHER		MOTHER	
FULL NAME <u>Home Francis Altig</u>	FULL MAIDEN NAME <u>Lora Annie Chute</u>		
RESIDENCE <u>Caldwell</u>	RESIDENCE <u>Caldwell</u>		
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>27</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Harmon S. D.</u>	BIRTHPLACE <u>Idaho</u>		
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>		

Number of child of this mother, including present birth, One Number of children of this mother now living, including present birth, none

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1:10 P. M.  
on the date above stated. (Born alive or stillborn)

(Signature) Dr. Dora A. Heymouth  
(Physician or midwife)

Given names added from a supplemental report \_\_\_\_\_

Address Caldwell Idaho  
Filed Dec. 6 1922 John V. Meyer  
Registrar

8-Y CO. 20174

2. V. 4. 11

OHAN

181712

181712

## 1. PLACE OF DEATH

County of *Canyon*City of *Caldwell*

If death occurs away from usual residence, give facts called for under special information.

## 2. FULL NAME

RECEIVED

## CERTIFICATE OF DEATH

Registration District No. *3*Primary Registration District No. *2005*

State of Idaho  
BOARD OF HEALTH  
Bureau of Vital Statistics

File No. *35939*Registered No. *170*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

## 3. SEX

## 4. COLOR OR RACE

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

*Female white*

(Write the word.)

## 6. DATE OF BIRTH

*Nov. 21 1921*  
(Month) (Day) (Year)

## 7. AGE

IF LESS THAN 1 day

how many \_\_\_\_\_ hrs.

or \_\_\_\_\_ min.?

## 8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

## 9. BIRTHPLACE

(State or Country) *Idaho*

## 10. NAME OF FATHER

*H. F. Altig*

## 11. BIRTHPLACE OF FATHER

(State or Country) *South Dakota*

## 12. MAIDEN NAME OF MOTHER

*Laura Chute*

## 13. BIRTHPLACE OF MOTHER

(State or Country) *Oregon*

## 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *H. F. Altig*(Address) *Caldwell, Ida.*

## 15. Filed

*Nov. 21 1921*Local Registrar *John H. Meyer*

## 16. DATE OF DEATH

*Nov 21 1921*  
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Nov 20-21 1921* to *19*

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19

and that death occurred on the date stated above, at *1:00 PM*

The CAUSE OF DEATH\* was as follows:

*Still born*

(Duration) \_\_\_\_\_ Yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *Dora A. Heymuth**Nov 21 1921* (Address) *Caldwell*

\*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

## 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ days

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

## 19. PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

*Pleasant Ridge**11-21-1921*

## 20. UNDERTAKER

## ADDRESS

*V. Beckham**Caldwell*

2  
9  
1  
A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

**STATEMENT OF OCCUPATION.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**STATEMENT OF CAUSE OF DEATH**—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

958 019 028 154

PLACE OF BIRTH

RECEIVED

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

U. S. No. 11-C-25m-9-8-16

County of Ada

AUG 22 1921

CERTIFICATE OF BIRTH

S 114545

City of Spirit Lake, Ida.

BUREAU OF

Registration District No. 4

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD

Miscarriage 3rd mo

Sex of Child <u>?</u>	Twin Triplet or other? (To be answered only in event of plural births)	1 { and { Number in order of birth	Legiti- mate? <u>fr</u>	Date of Birth <u>10-19-1921</u> (Month) (Day) (Year)
FULL NAME <u>for Reynolds</u>		FULL MAIDEN NAME <u>Dorothy Anderson</u>		
RESIDENCE <u>Spirit Lake Ida</u>		RESIDENCE <u>Spirit Lake Ida</u>		
COLOR <u>Wh</u>	AGE AT LAST BIRTHDAY <u>41</u> (Years)	COLOR <u>Wh</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)	
BIRTHPLACE <u>Ida</u>		BIRTHPLACE <u>Mont</u>		
OCCUPATION <u>See 4 mo</u>		OCCUPATION <u>Housewife</u>		

Number of child of this mother, including present birth 7Number of children of this mother now living, including present birth 5

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was Miscarriage 3rd mo, at 10 P. M. on the date above stated.

(Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) D. H. Smith M.D.

(Physician or midwife)

Given names added from a supplemental report.

Address Spirit Lake, Ida.Filed 9/14 1921

Registrar

Registrar





613 717-028 395  
PLACE OF BIRTH

Form V. S. No. 11-C—26m-9-9-15

STATE OF IDAHO  
BUREAU OF VITAL STATISTICS

RECEIVED

CERTIFICATE OF BIRTH

County of Kootenai

AUG 22 1921

S 1/4548

City of Spirit Lake, Ida.

BUREAU OF VITAL

Registration District No. 45

File No. \_\_\_\_\_

No. \_\_\_\_\_ St. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Hospital \_\_\_\_\_

FULL NAME OF CHILD Brunahue Luker

Sex of Child <u>m</u>	Twin Triplet or other? <u>1</u>	and { Number in order of birth	Legiti- mate? <u>no</u>	Date of Birth <u>12-17</u> 19 <u>21</u> (Month) (Day) (Year)
-----------------------	---------------------------------------	--------------------------------------	----------------------------	---

FATHER		MOTHER	
FULL NAME <u>John Wallace</u>	FULL MAIDEN NAME <u>Lillian Shields</u>	FULL NAME	FULL MAIDEN NAME
RESIDENCE <u>Spirit Lake Ida</u>	RESIDENCE <u>Sp L</u>	RESIDENCE	RESIDENCE
COLOR <u>Wh</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)	COLOR <u>Wh</u>	AGE AT LAST BIRTHDAY <u>18</u> (Years)
BIRTHPLACE <u>Wis</u>	BIRTHPLACE <u>Sweden</u>	BIRTHPLACE	BIRTHPLACE
OCCUPATION <u>man</u>	OCCUPATION <u>domestic</u>	OCCUPATION	OCCUPATION

Number of child of this mother, including present birth 0Number of children of this mother now living, including present birth 0

## CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was still born 4th mo at 11 P M.  
on the date above stated.

(Born alive or stillborn)

\* When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) E. J. Smith M D

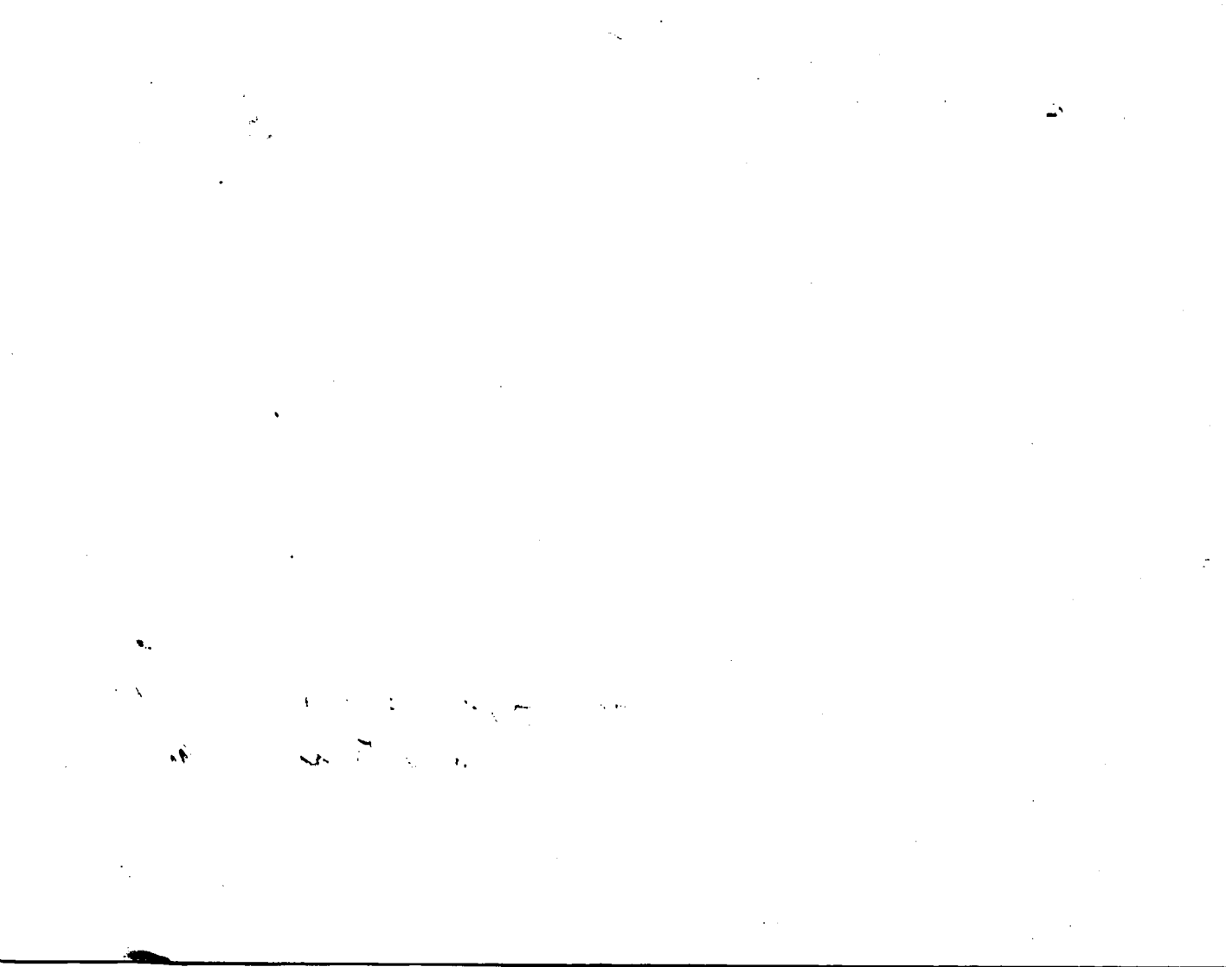
(Physician or midwife)

Given names added from a supplemental report.

Address Spirit Lake, Ida.Filed 10/17 1921

Registrar

Registrar



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each  
and the number of each, in order of birth stated.

463 127001 403  
PLACE OF BIRTH

RECEIVED  
AUG 6 1926  
BUREAU OF VITAL STATISTICS  
STATE OF IDAHO  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

County of Ada  
City of Boss  
Registration District No. 2 File No. 142962  
No. \_\_\_\_\_ St. \_\_\_\_\_  
Hospital St. Luke's Primary Registration District No. 1004 Registered No. 261  
FULL NAME OF CHILD Infant Dotson

Sex of Child M Twin Triplet { and { Number in order of birth 1 Legiti mate? No Date of Birth 6 - 27 - 1926  
(To be answered only in event of plural births) (Month) (Day) (Year)

FATHER  
FULL NAME Ralph Poutt  
RESIDENCE Penitentiary  
COLOR W AGE AT LAST BIRTHDAY 28  
(Years)  
BIRTHPLACE ?  
OCCUPATION Penitentiary

MOTHER  
FULL MAIDEN NAME Maurel Dotson  
RESIDENCE U. Eagle  
COLOR W AGE AT LAST BIRTHDAY 19  
(Years)  
BIRTHPLACE Idaho  
OCCUPATION working girl

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE\*

I hereby certify that I attended the birth of this child, who was still born at 11 a M.  
on the date above stated. (Born alive or stillborn)

\*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) CH Parker

(Physician or midwife)

Given names added from a supplemental report.

Address 303 W. E. Carty Bldg  
Filed 7-8-26 19 Robert K. Pratt  
Registrar

Registrar

Registrar

UNION TRAVEL AGENCY  
 1010 14th St. N.W.  
 Washington, D.C.  
 Tel. 4-1234

# ALBION CERTIFICATE OF BIRTH

City of <u>Albion</u> St. <u>1st</u>		Registration District No. <u>4</u> Registered No. <u>100</u>	
Full Name of Child <u>John Doe</u>		Registered No. <u>100</u>	
Sex <u>Male</u> Date of Birth <u>1/1/1900</u> (Day) (Month) (Year)	Place of Birth <u>Albion, Mich.</u> (City) (State) (Country)	Age at Last Birthday <u>10</u> (Years)	Color <u>White</u>
Full Name of Mother <u>John Doe</u> Maiden Name <u>John Doe</u> Residence <u>Albion, Mich.</u>	Full Name of Father <u>John Doe</u> Maiden Name <u>John Doe</u> Residence <u>Albion, Mich.</u>	Occupation <u>Teacher</u>	Occupation <u>Teacher</u>
Number of children of this mother now living, including present birth <u>1</u>		Number of children of this mother now living, including present birth <u>1</u>	
Certificate of Attending Physician or Midwife I hereby certify that I attended the birth of this child, who was (Born alive or stillborn) <u>Born alive</u> (Physician or midwife) <u>John Doe</u> Address <u>100 1st St. Albion, Mich.</u> Filed <u>1/1/1900</u> Registered <u>1/1/1900</u>			

Other names used on a subsequent report  
 Name of child at birth  
 Name of mother at birth  
 Name of father at birth  
 Name of child at birth  
 Name of mother at birth  
 Name of father at birth